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ABSTRACT

Three papers and four task force reports from a 1979 conference on the state of the art in early intervention for developmental disabilities are presented. J. Gliedman, in "Social, Psychological, and Ethical Foundations for Early Intervention for the Developmentally Disabled," applies a minority group model to the education of handicapped children. In "Current Status in Research Relating to Model Development and Early Intervention for Young Handicapped Children," N. Anastasiow considers findings on types of models, age of intervention, and agent and environment of stimulation, and suggests that to be effective, early intervention must focus on the caregiver, be continuous over time, and consider the child's social environment. E. Jackson ("Current Status of Personnel Training for Early Intervention Programs") describes four major training efforts: the National Diffusion Network, the Bureau of Education for the Handicapped, Project Head Start, and Parent-Child Development Centers. The task force reports emphasize four aspects of future services: community mobilization, program implementation, personnel preparation, and evaluation and dissemination. (CL)

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Early Intervention of Developmental Disabilities

A report of the Conference on Early
Intervention of Developmental Disabilities

Nashville, Indiana
May 18 and 19, 1979

Edited by:
Susan K. Shuster
Susan L. McBride

Sponsored by:

The Ohio State University Research Foundation in conjunction
with the Region V UAF Consortium Project

and the
Early Childhood Unit
Developmental Training Center
Indiana University

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Preface

About the Early Childhood Unit . . .

The Early Childhood Unit of the Indiana University Developmental Training Center serves as a catalyst for the provision of comprehensive services to young handicapped children and their families from birth to five years of age.

The Unit considers itself a model for demonstrating the delivery of comprehensive and interdisciplinary services, and a training site for pre-service and in-service professionals, paraprofessionals, and parents. Research and inquiry related to parent-child interactions, instructional strategies, and other topics are seen as key activities in the Unit. It is committed to maintaining the service functions already in operation through demonstration, training, and research, while building upon this base to extend and expand its field-based consultative effort.

The Early Childhood Unit currently consists of two model demonstration programs and a curriculum development project. Program PREPARE, formerly a federally-funded model demonstration program for handicapped infants and toddlers and their families, is now state-supported and provides services to families of young handicapped children as well as technical assistance to service providers within Indiana.

The Monroe County Multi-Categorical Model Preschool Program is a federally-supported model demonstration program for handicapped preschool children ages 3-5. A joint effort with the Monroe County Community School Corporation and the Indiana Department of Public Instruction, the preschool has as its goal the successful integration of handicapped preschoolers into the public school.

The *Indiana Home Teaching System,* formerly funded by the Indiana Department of Mental Health and now funded by Region V HEW Developmental Disabilities Office, is designed to provide a comprehensive, coordinated, cost-effective system for young handicapped children and their parents living in rural areas. Currently being field tested in the six states of Region V, it is designed for agency and/or home utilization.

The Early Childhood Unit personnel also work closely with the Preschool Consultant of the Division of Special Education in the Department of Public Instruction for purposes of training, dissemination, and technical assistance.

Introduction and Conference Overview

Introduction: In January, 1979, the Early Childhood Unit of the Indiana University Developmental Training Center was awarded a contract by the Ohio State University Research Foundation in conjunction with the Region V UAF Consortium Project. The purpose of the contract was to plan, develop, and conduct a State of the Arts Conference dealing with early intervention of developmental disabilities which would provide imput to a regional futuristic conference on developmental disabilities.

The purposes of the conference, as defined by the Early Childhood Unit, were as follows:

1. To enhance knowledge about early intervention strategies and their effectiveness;
2. To facilitate the identification and coordination of various state and federal programs;
3. To utilize current knowledge of programs and practices in the planning for the future;
4. To produce futuristic guidelines that reflect the content of the conference and can be utilized for future planning.

Organization of the Conference: The conference was held on May 18 and 19, 1979, in Nashville, Indiana. It included the presentation of three papers, followed by discussion among participants and small task force discussions on four predetermined topics.

The first paper, Social, Psychological, and Ethical Foundations for Early Intervention for the Developmentally Disabled, was delivered by John Gliedman, Ph.D. and addresses the application of a minority group model to the educational problems of handicapped children.

The second, Current Status in Research Relating to Model Development and Early Intervention for Young Handicapped Children, was delivered by Nicholas J. Anastasiow, Ph.D. It presents an overview of the model early intervention programs, and deals with research findings and program effectiveness.

The third paper, Current Status of Personnel Training for Early Intervention Programs, was delivered by Elouise Jackson, Ph.D. This paper describes the training efforts of four major systems involved with providing services to handicapped children: the National Diffusion Network, the Bureau of Education for the Handicapped, Project Head Start, and Parent-Child Development Centers.

Initial discussions addressed a definitional problem, the need to identify the nature of the population for whom early intervention was being recommended. The participants agreed that the focus of the discussion/conference was the child, chronologically 0-8 years, who is impaired in that there exists some kind of interference in the child's ability to use his brain, nervous system, and/or his visual, tactual, and auditory modes in mastering his/her environment. The term *developmental facilitation* was selected by the participants to express the main topic of the conference, because it avoids the negative connotations of the more familiar term *intervention,* which, it was felt, accentuated problems associated with the social pathology model that has so long characterized the field.

With agreement as to the population to be served and the kind of service desired, task forces were then formed to prepare futuristic guidelines for the following areas: Community Mobilization, chaired by Myrtle Scott, Ph.D.; Program Implementation, chaired by Howard Spicker, Ph.D.; Personnel Preparation, chaired by Susan Shuster, Ph.D.; and Evaluation and Dissemination, chaired by Egon Guba, Ph.D.

The three papers and the four task force reports are included in this document.

Conference Participants: The conference participants were representatives from departments of public instruction, departments of mental health, federal and state model programs, University Affiliated Facilities, as well as instructors from institutions of higher education, parents, and graduate students.

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Special Education and Minority Education:
The Path Not Yet Taken—

Social, Psychological, and Ethical Foundations for Early Intervention for the Developmentally Disabled

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In a famous lecture of twenty years ago Sir Charles Snow spoke of the problem of the "two cultures"—of a gap between how the world is viewed by those trained in the humanities and by natural scientists. Increasingly, Snow claimed, humanists and scientists talk past each other. Each has valuable insights, yet lacking a common language, each has great difficulty communicating these insights to the other. My theme is about another kind of cultural divide—that of the different way experts view the educational problems of handicapped children and of able-bodied minority group children. Here too there is a basic difference in intellectual frameworks. But something more than a bridge between these two paradigms is needed. If special education is to flourish, and if early intervention programs are to progress, a new intellectual integration will be required. In the pages that follow I shall suggest why this integration is so important, why it has been so long in coming, and the main directions that it is likely to take.

The Social Pathology Model in the Past

A generation ago there was no two cultures gap in education. A single model informed the way that educators perceived, studied, and attacked the school problems of minority group children and handicapped children. Following a number of recent critics—as well as traditional practice—I shall refer to this paradigm as the social pathology model.[1] As its name suggests, this model was patterned after the physician's approach in intervention in acute illness. The child's problems were defined as deviations from the universal norms of childhood, much as the doctor defines disease as a deviation from the norm of physical health. Then—and the analogy to medicine is exact—the educator devised special programs to help the child compensate for his educational deficiency. This focus on compensation encouraged the educator to interpret the developmental significance of the child's behavior with little or no reference to its meaning in the context of the social environment, for by definition a deviation from a universal has an absolute character. Just as measles is the same disease regardless of the race, sex, or social class of its victim, so too, an educational deficiency has the same meaning regardless of the child's cultural milieu. Of equal importance, the social pathology paradigm encouraged the educator to define individualized instruction in a manner resembling the way the doctor treats an acute disease. By "individualized" it meant: compile a comprehensive catalogue of the child's deviations from the norms of his age group. No child is exactly the same, but it was assumed that a sufficiently refined diagnosis of his deficiencies would serve to distinguish him from other children with school problems.

During the 1960's special education remained true to the medical model, but those who worked with minority group children slowly began to adopt a different approach. By the end of the decade, a new perspective on minority education had taken shape. Increasingly, those who worked with minority group children argued that the field's traditional reliance on compensatory strategies was wrong.[2] Far from helping the child better cope with the demands of the classroom, the emphasis on compensation diverted the teacher's attention from the many strengths displayed by inner-city children, conveyed the sociological message that the school considered them to be inferior, and confused culturally-determined differences in normal behavior and cognitive style with pathological deviations from the norms of child development. In place of the traditional approach, educators like Mario Fantini and Gerald Weinstein proposed "contact strategies," attempts to help the child apply the learning styles fostered by his social and cultural experience to the tasks of the classroom.[3] As Frank Riessman has noted, these approaches are far more successful than the compensatory methods inspired by the social pathology model.[4]

A start was also made towards understanding how the child's perceptions of race stereotypes, prejudice, and discrimination affect his development. Building on the earlier work of the Clarks, many studies found that by age three black children have started to internalize society's stereotypes about race.[5] This result further undermined the social pathologist's claim that the minority child's school and pre-school behavior can be safely assessed by the same criteria customarily employed with white middle class children, because at an early age the child already sees himself as different. Recent work by

John Ogbu has gone still further.[6] Ogbu's research suggests a direct connection between the black child's generally poorer academic achievement and his perceptions of the second class social status of black adults. Ogbu found that black children often take school and school-related activities less seriously than white children because they are aware that the ultimate social benefits of school achievement are much smaller for black people than for whites. These findings have not yet been generalized to pre-schoolers, but they raise important questions about the ways that apparently pathological cognitive and social behaviors in very young minority children may represent developmentally appropriate responses to what they see in the world around them.

The educator's growing dissatisfaction with the traditional premises of minority education has also led to a reappraisal of the role played by the social pathology model in parent education programs.[7] For decades the concensus view was that lower-class parenting styles were more or less pathological deviations from the middle-class ideal. If these deviations could be corrected by parent education, the disadvantaged child could bring to the classroom a set of behavior and cognitive skills more conducive to subsequent academic achievement than those he would otherwise acquire. Especially in the past few years critics have pointed to many crucial flaws in this analysis. Perhaps the most important of these criticisms is that middle-class parenting strategies that correlate with good school performance simply may not be appropriate for helping the member of a politically and socially oppressed minority succeed in school, let alone cope with the daily strains of poverty and discrimination. Indeed, far from helping the child, the professional's didactic efforts actually may be harmful—by suggesting that experts believe the parents belong to an inferior social group, by conflicting with values (such as the importance of discipline and order) that may be highly prized in the parents' subculture, and by otherwise undermining the parents' sense that they are competent care-givers.

Finally, policy-oriented research has led to a new understanding of the role that education can play as an agent of major social change.[8] Guided by the social pathology model, generations of reformers pinned their hopes on the schools. They reasoned that if the minority group child could be cured of his educational pathologies, he would do as well in school as the average American child, and that if he met the educational standards of the mainstream, his chances of escaping from poverty would be greatly enhanced. The research of Christopher Jencks and his associates suggests a different conclusion: even after the leveling of all educational differences between the races, substantial racial differences in income, wealth, and occupational distribution would remain.[9] Education alone, argues Jencks, is a weak tool for economic change, and only massive social and political reforms can eliminate the unfair economic advantages that the white majority currently enjoys.

However, other research does suggest that education is a very good social insurance policy. For example, during a period of massive structural reforms in society, improved schooling can help a minority group take full advantage of its new social options. Moreover, there is ample evidence that minority groups must constantly upgrade their educational credentials simply to retain their traditional share of jobs and income during periods, such as our own, when educational requirements for most kinds of work are continually rising.[10]

Special Education and the Social Pathology Model

Experienced workers in special education agree that prejudice and discrimination are important factors in the lives of many handicapped children. In the absence of social reforms, experts agree that economic and social discrimination will fetter many handicapped children when they become adults a decade or two hence—even if these children receive first-rate educational services while they are growing up.

Professionals are acutely aware of the shortcomings of society's general view of the nature of disability. They agree that what the man in the street understands about the handicapped child's innate abilities is frequently a social invention, a product of stereotypes and prejudices about the nature of

disability no different in kind from the racist's belief that blacks are innately inferior to whites.

Why, then, given this broad concensus about the importance of social context, does special education continue to ignore (or insufficiently emphasize) the ways that stigma and discrimination may shape the handicapped child's mental and social development? Why isn't special education full of attempts to do justice to *both* the social pathology model and the minority group model? Why not strike a balance between focusing on the often overwhelming biological limitations, and on those aspects of a child's problems best approached using the insights of minority group analysis? Why is there a two cultures problem in education, a sharp divergence between the way that the educator approaches the minority group child, and the way that he approaches the handicapped child? Perhaps most puzzling of all, why is there so little awareness among professionals that there is a two cultures problem?

The special characteristics of the handicapped child's minority-group status certainly contribute to this highly unsatisfactory stage of affairs.[11] Black and hispanic children have black and hispanic parents, and both blacks and hispanics form distinct (if highly diverse) cultural communities. In contrast, most handicapped children have able-bodied parents and siblings, and disabled people do not form anything like a distinct cultural community. This lack of an obvious minority-group identity means that the disabled face some of the same problems of group visibility as women, gay people, and the elderly, all of whom have achieved general standing as disadvantaged or oppressed social groups only as the result of vigorous efforts to claim their legitimate civil rights. Because the disability civil rights movement is new, disabled people have had less time than most other disadvantaged segments of the population to argue the case for a minority-group analysis with professionals and with the public at large.

But there is, I believe, a more fundamental reason why the recent changes in minority education have not had a significant impact on special education. Many years ago the social psychologist Kurt Lewin discussed the role that society plays in defining a collection of individuals as a distinct social group.[12] Speaking of the situation of European Jews in the 1920's and 1930's, Lewin noted that the members of an oppressed minority often have little more in common than the fact that society singles them out for systematic discrimination. He called the defining characteristic group an "interdependence of fate," and argued that the social expectation was that the lives of those in the group would follow a similar pattern. Lewin's use of the word "fate" points to what is perhaps the most important reason for the two cultures problem in education. Oppressed groups, such as those described by Lewin, are given social reality by the fact that their members are seen to share a common sociological or political destiny. American society has traditionally acknowledged that disabled people share an interdependence of fate, but it has blamed their problems only on a biologically determined fate, and not on a destiny that is in part socially produced. As the dictionary definitions of "disability" and "handicapped" suggest, disabled people are defined as those individuals whose biological limitations exclude them from normal pursuits or seriously imperil their ability to lead a normal life. But society's emphasis on the biological nature of disability has constantly impeded the efforts of the disabled to secure their most elementary civil rights. (The opinion recently handed down by the Supreme Court in the Davis case eloquently testifies to the scope of this problem.[13]) In special education too the prevailing interpretation of disability as biological has played a harmful role, for it has ranged our commonsense intuitions about the nature of disability on the side of the social pathology model.

I know no better way to suggest how much the social pathology model owes its continued dominance in special education to the cultural meaning of disability than by briefly examining a few of the "deep structure" rules that govern able-bodied society's phenomenological definitions of disability. These definitions seem to be part of everyone's cultural baggage, layman and professional, handicapped and able-bodied. Subtle and all-pervasive, they contribute to a Zeitgeist that makes it hard to perceive the existence of a two cultures problem in education, a cultural background that obscures many of the most important similarities between special education and minority education. Perhaps most important, these concepts create mental sets that prevent the educator from integrating his (often

extensive) first-hand experience of the social dimension of disability with the actual strategies of research and intervention that he pursues in his work.

Handicap as a Social Construction[14]

Conjure up in your mind a military man with an eye-patch. Is there not something romantic and heroic about the injury? Doesn't it suggest a dark and complex past, a will of uncommon strength, perhaps a capability for just enough brutality to add an agreeable trace of sinister and virile unpredictability to the man? Depending on one's politics, it can suggest a resourceful ally or a dangerous enemy. Mustn't a man be tough and competent to escape so lightly from what must have been a brush with death? No doubt these reactions explain why Madison Avenue once used a disability to enhance the glamour (and salability) of a commodity, in the Hathaway Shirt ads of the 1960s.

Now replace the image of the Hathaway Man wearing an eye-patch with the image of a seven-year-old girl who wears one. For most people, something happens. The romance and mystery disappear. What we see is a handicapped child. There is something sad and even pitiful about her; we fear for her future and worry about her present. We think: this poor kid is going to have a hard time growing up and making it in this world. Where the presence of an eye-patch made an Israeli leader seem even more of a general (an adult role), the presence of an eye-patch on a child is a sign of damage, a cause for pity, an indication that this is a child whose ability to fit into some adult role in the future is in jeopardy.

Similar shifts in valence occur with numerous minor disfigurements or cosmetic blemishes, as an acquaintance of mine learned to his astonishment when, after a hiking accident that left him hobbling about for several weeks, he was told by a number of friends that he looked so distinguished using a cane that he should consider always using one. Needless to say, this is not something that one says to a young child similarly disabled.

Many striking illustrations of the impact of social function on the perception of a handicap are found in films. For example, in Jean Renoir's *Grand Illusion,* Erich von Stroheim plays the part of a German commandant with a brace under his chin, a lame leg, a body scarred by burns, and a back injury which requires that he wear a steel corset. While this enumeration suggests a severely disabled man, we do not perceive the commandant as handicapped, because our tacit social grammar responds to his character, his job, and the period during which the film is set so as to make his disabilities recede into the background.

To begin with, the movie is set during wartime, and during war our tacit definitions of disability are relaxed. We adopt a saner approach. What counts is not so much how a man looks (within limits) but whether he can still function. This German officer is perfectly capable of discharging the duties of his assignment behind the lines.

In addition, the social identity of the character von Stroheim plays helps to block our tendency to see him as handicapped. An old Prussian aristocrat with a spartan sense of morality and honor, his fidelity to the symbols of his social position—fastidious appearance, perfect manners, a deliberate cultivation of an aesthetic sense—makes it impossible for us not to regard the man as a social adult. Finally—and perhaps most important—his military duties as commandant of a prisoner-of-war directly conflict with the attribution of social powerlessness which stands at the core of able-bodied society's definition of handicap. This technically disabled officer controls the lives of hundreds of able-bodied prisoners.

Similar transformations in our conventional perceptions of particular disabilities occur when the bearer is a movie villain: one of those real-world deviants who are granted a conditional legitimacy in our fantasies, provided, of course, they are defeated in the end. Here too even severely incapacitating handicaps can signal that, far from being a pitiful social incompetent, the villain is usually resourceful and cunning. Hence the false arm of Dr. No in Ian Fleming's James Bond thriller, *Dr. No* or the Smersh factotum in Fleming's *From Russia With Love,* a thug with a hook on his arm which can cut through metal and glass. Neither do the cluster of disabilities that afflict Dr. Strangelove in Stanley Kubrick's film of that

name—an arm not fully under his control, and partial paralysis which results in his being pushed about in a wheelchair and wearing braces on his legs—cause us to view this president's advisor as handicapped, for all of these villains are highly effective within their special roles.

Each of these examples of "positive" handicaps represents a kind of gift of social convention, a physical trait which, in certain settings and for certain social roles, enhances, or at least does not actively undermine, the individual's claim to be taken seriously as a social being. It is the magnitude of this gift that commands our attention. In contrast, the racist's perception of a black individual as a member of the "Negro race" remains unchanged regardless of whether the black is perceived as a deviant (e.g., a Nat Turner) or as a loyal and capable house servant. However, there is no such thing as a "good" handicap. In those rare instances in which the able-bodied world's social grammar decrees that, for a certain role in a certain setting, a disability is not socially incapacitating, the person is simply perceived as not suffering from a condition: he is permitted to pass over into the world of social normals.

For most handicapped individuals, the rules of the able-bodied world's tacit social grammar work against them. In nearly all cases, the cripple, the blind man, even the adult who admits to a reading disability must overcome the world's working hypothesis that, until proven otherwise, the handicap renders the individual incapable of fulfilling the social roles expected of able-bodied individuals of similar age, sex, and social background. Overcoming this presumption of inferiority requires a sociological *tour de force.* Because the attributes "successful" (excelling in one's social role) and "handicapped" are mutually incompatible, the able-bodied world finds it almost impossible to perceive of a successful individual as also handicapped. But for the person with a handicap this contradiction also provides a social loophole which, in rare circumstances, he can exploit. Defined by society as a conspicuous failure, the disabled person can prove that he is the exception to the rule *if* he can achieve a conspicuous success in some area of life.

How this success affects the way disabled persons are remembered demonstrates dramatically the arbitrary way in which the able-bodied world perceives of handicaps as biological conditions. We do not think of Franklin D. Roosevelt as a great crippled president; we think of him as a great president who, among many other things, happened to be crippled. Nor do we customarily think of John F. Kennedy as a handicapped president cut down before he could fulfill his promise. Yet he suffered from Addison's disease, a chronic illness that qualifies its bearer to carry the handicapped label. And while both Alexander the Great and Julius Ceasar were epileptics, it takes Jose Luis Borges (himself blind but not considered handicapped) to remind us that in Caesar's case, his handicap changed the course of history.*

Nor do we remember above all that Byron had a club foot and Pope curvature of the spine. Elizabeth Barrett Browning was a paraplegic. Milton was blind when he wrote *Paradise Lost,* Beethoven deaf when he wrote the Ninth Symphony; Nietzche was a syphilitic, Doestoevsky an epileptic. Numerous poets from Keats on have been tubercular. Edison was deaf, and Freud spent the last sixteen years of his life wearing a prosthesis on his jaw. To speak of these men and women as handicapped seems a contradiction in terms. It seems so, we believe, because success means that a chronologically adult individual can carry out certain adult functions so well that his inability to perform other adult functions is judged irrelevant.

Again, note the contrast with society's traditional racist perceptions. Merely to mention such individuals as Paul Robeson, Jackie Robinson, and James Baldwin is to signal the difference between being perceived as the member of a social group, however stigmatized the group may be, and being perceived as the victim of a condition that defines one as incapable—until proven otherwise—of fulfilling any positive role in normal society. Because Paul Robeson or James Baldwin cannot escape their racial

* While swimming in the Rhine, Caesar had a seizure and nearly drowned. Only rescue by a soldier from shore saved his life, and as a result of the incident, Caesar decided not to mount a major invasion of what is now Germany.

identification, their conspicuous success works to discredit traditionally demeaning stereotypes about blacks. But in the past at least, the example of the successful disabled person has not similarly conflicted with beliefs about the abilities of handicapped people in general. Instead, the successful person has been perceived as in effect escaping from his condiction. He has not challenged our belief that handicapped people are socially incompetent as a rule. Rather he has persuaded us that he is an exception to that rule, the one man in a thousand who has overcome the incredible odds of his liability and has achieved a positive social identity.

If a similar state of affairs prevailed in race relations, every black would "escape" the category of black the moment he achieved conspicuous success. The class of black individuals would, by definition, always consist of individuals who were social failures or only capable of the modest social roles traditionally accorded blacks in American society.* While this analogy may seem extreme, it not only captures the logic of lay society's traditional idea of disability, but also represents the operational definition of disability that has been employed in nearly all government surveys of the general demographic characteristics of disabled adults. Virtually all surveys of the employment of disabled adults have traditionally excluded from their count any blind man, cripple, or other handicapped person who does not describe himself as economically disabled by his handicap—that is any disabled person whose success has allowed him to escape even official recognition of his condition.

All of these examples illustrate how our apparently objective perception of handicaps as socially incapacitating biological conditions are the products of a prior—and unconscious—social construction. Only when our tacit social grammar decrees that the disability is a stigma of deviance do we *see* a handicapping condition. But the moment that grammar decrees otherwise, either because of conspicuous success or because of some combination of social role and setting, we cease to perceive a handicapping condition. Thus, it is not the biological characteristics of the disability *per se* that determine our perception of it, for this can be overcome, as we have seen. Far from being a response to an unalterable biological fact, our perception of a handicap nearly always reflects the way our social grammar treats normal social function and the possession of a handicap as mutually exclusive attributes. No wonder, then, that we find it so natural to continue to apply the social pathology model to the handicapped child. That paradigm confirms our culture's perception of disabilities as socially incapacitating kinds of deviance, and logically suggests a strategy for dealing with this kind of deviance in the most humane and moral fashion possible.

Consequences for Special Education

Even today, during a period of unprecedented advance, special education pays a heavy price for its exclusive reliance on the social pathologist's analysis of the handicapped child's needs. We deplore the stigma and discrimination that the handicapped person faces in childhood and adulthood, yet we do not explore the adjustments these special socialization experiences require in the design of early intervention strategies, of strategies for older children, and in the advice we provide the handicapped child's parents. No other child in America can experience such extreme social contrasts in a single day, let alone over the course of a childhood: love, understanding, and stimulation at home, intense stigma in the classroom, and, from all too many adults, the tacit message that society's concept of disability is indeed correct, that the child is nothing more than his condition. No other group of disadvantaged children contains so many children who are physically different from their parents and sociologically different as well. Nor does any other group of children contain so many individuals who, because of the physical

* Something like this may be the case in Brazil where social status appears to significantly alter perceptions of race membership and where, as the Brazilian saying goes, "money whitens."

limitations and social stigma they face, have such powerful incentives for channeling their best mental and emotional energies into learning to manipulate the rules of social interaction to their own advantage. These sociological facts cry out for integration into a broadly based educational strategy for the handicapped child and his parents.

Let me emphasize that I am calling for an integration that would join the best elements of the traditional paradigm with those insights into the role of social context that have been gained by workers in the field of minority education. For while concerning minority education, the perspectives of the social pathologist and the civil rights advocate are often opposed, they nicely complement each other when applied to the far more complex family of educational problems posed by disability. The social pathology model plays a valuable role in special education whenever consideration of the medical aspects of the child's disability is appropriate. It is also useful as a guide to some of the most immediate obstacles to the severely handicapped child's intellectual and social growth—the barriers to information gathering, data interpretation, social communication, and self expression that stem from biological limitations. The model encourages us to do everything possible, for example, to help the blind child compensate for his lack of visual inputs, perhaps by providing him with compensatory auditory and tactile stimulation. It urges us to compensate as much as possible for the retarded child's slower mental development, possibly by exposing him to an array of enrichment experiences or by giving him intensive training in discrete skills. Similarly, the model directs our attention to finding ways to compensate for the cerebral palsied infant's poor motor coordination—to do whatever we can to meet his developmental need for interaction with the environment, in the face of a diminished ability to actively manipulate and explore the physical and social world.

However, when it comes to suggesting specific strategies for aiding the handicapped child's development, the social pathology model is highly unsatisfactory, and it must be supplemented by a perspective like that useful in understanding minority group problems. The basic difficulty is that existing theories of infant and child development uncritically assume that all children, regardless of temperament, cultural background, or social experience, pass through essentially the same stages of development. However, no theory—not even Piagetian cognitive theory—can provide convincing support for this claim. Still less has any developmental approach seriously confronted the special theoretical challenges posed by the handicapped child, whose pathways of optimal development may differ from able-bodied norms because of his physical or mental differences, his often extraordinarily complex socialization experiences, or some combination of these factors. Because it rigidly imitates medical modes of explanation, the social pathology model rules out in advance any consideration of these issues. Indeed, so powerful is the paradigm's influence, it prevents most educators from even perceiving that these problems pose legitimate questions for research, let alone that they are of the highest practical importance.

Up to now, even the boldest innovators in special education have taken for granted the existence of universal norms of child development, norms that hold for handicapped children as well as for the able bodied. They have ignored the possibility that some handicapped children may develop according to a healthy logic of their own. Yet given our present understanding of child development, this hypothesis must be treated as seriously as the conventional notion that all children move through the same developmental stages, pass through these stages in the same invariable sequence, and that all major deviations from age specific developmental norms represent pathological aberrations requiring compensatory intervention.

The widespread acceptance of able-bodied norms for child development casts a long shadow over the many reforms now underway in the education of handicapped children, and it is likely that present day developmental criteria discriminate against children with handicaps. Forestalling this possibility requires more than general exhortations about the importance of adopting a developmental perspective suited to special education, although such efforts are important in a field that traditionally has treated

many handicapped children as small patients rather than growing children. Painstaking basic research is required, research that tests the applicability to handicapped children of virtually every developmental theory, from Piagetian cognitive theory to Kohlbergian moral theory to the major theories of personality development. This research will be costly and time consuming. It will have to be carried out for each major disability group, and it will have to take into account a host of complex social variables, not the least of which are ethnic group, social class, age, and gender. Yet unless this research is conducted, we shall be basing our intervention strategies on mere supposition rather than on the firm result of empirical investigation, and the issue is far too important to be decided by fiat.

The social pathology model is equally unsatisfactory as a tool for constructing the psychometric and clinical tests that we need to assess the handicapped child's development. Whether the test is one of intellectual aptitude or social maturity, our present diagnostic armamentorium either imposes able-bodied norms on the handicapped child or, as in the case of intelligence tests for the blind and deaf, applies to a disabled population testing methodologies of dubious value for even able-bodied children, let alone children with handicaps. Lacking valid ways to assess the handicapped child's growth, it is hardly surprising that it is difficult to demonstrate any consistent long term benefits from early intervention programs in the child's academic performance or general development. Because of their reliance on norms for the able bodied, conventional assessment procedures may look at the wrong aspects of the child's behavior, and they may misinterpret the significance of the behavior that they do examine. Here too, the social pathologist's assumption that able-bodied norms do not discriminate against handicapped children must be subjected to careful experimental scrutiny.

Many of the most important advantages in using the minority group model involve the handicapped child's parents. They need an overview of the relative importance of biological and social factors which limit their child as part of a complete diagnosis of the effects of his handicap. Yet relatively few parents are likely to obtain this information from physicians, who, perhaps understandably, tend to emphasize the biological dimension of disability. And most parents are just coming to terms with discovering their child's handicap when they first meet with professionals to plan a special education program. For many of these parents, a minority group analysis can be far more than just another kind of information received from experts. It can help them come to terms with their child and with themselves. It can provide perspective on their guilt and anxiety, and it can suggest appropriate ways of redirecting their anger towards a society whose architecture, transportation systems, hiring practices, and prejudice often pose far greater barriers to their child's development and social independence than the physical or mental limitations connected with his disability.

A social analysis is especially important becuase most parents with handicapped children are themselves able-bodied. As a result they lack the first-hand experience of the discrimination and prejudice that will confront their child and that minority group parents automatically possess. Lacking a shared sociological destiny with the child, some parents have difficulty recognizing the many specifically social and political hazards that await the child during childhood and adulthood, and they may underestimate their child's immense stake in the success of the disability civil rights movement.

Psychologists generally agree that mother-child interactions play a crucial role in fostering the child's development in every area of life. Indeed, some of the most effective early-intervention programs—such as the one carried out by Phyllis Levenstein and her associates at the Verbal Interaction Project in Freeport, Long Island—have concentrated upon suggesting new ways for the mother to interact with her young child. That disability frequently impedes the normal flow of mother-child interaction is a common clinical observation. But how can one remove some of the barriers that can come between the mother and her handicapped child? Possibly a greater emphasis upon the social aspects of disability also may help to clarify these difficult questions. This is suggested by the findings of Thérèse Gouin-Décarie and Monique O'Neil concerning Canadian children born deformed because their mothers had taken the drug thalidomide:

> . . . This problem is not primarily a medical problem. It is first and foremost, a social problem. Let us but mention a single indication of this fact. The initial reactions of mothers of Thalidomide children, their perception of their child's handicap (which, moreover, continued to evolve over time) and their emotional relationship with their child was always a function of the social norms of the surrounding social milieu. In every case the seriousness of the malformation only played a secondary role.[16]

But the minority group model is not only best suited to exploring this possibility in a systematic fashion. It also reminds the educator that the parent is an adult whose decisions concerning the child must outweigh the professional's preferences in all but the most extreme instances of parental misconduct. As a consequence, it can serve as a useful corrective to the tendency of school personnel and other professionals to explain away the parent's attempts to have the last word about the child as symptoms of psychopathology. Again, an observation of Gouin-Décarie and O'Neil is apposite:

> Finally let us note in conclusion that the categories so often used in the work dealing with handicapped children (acceptance, rejection, over-protection, guilt feelings, etc.) appear to us to be neither adequate nor functional. The phenomena in question are so tightly intertwined with the sociological context that the methods of analysis of social psychology (especially those used to treat the problems of minorities) appear to be far better able to do justice to the reality [of the child's handicap] than the methods of analysis of clinical psychology . . . [17]

Towards Reunion in Education

If we are to resolve the two cultures problem in education, special education must profit from the experience of minority education. Something of the old culture—the field's traditional reliance on the social pathology model—will have to be retained, because only a medical model can do justice to the complex biological dimensions of disability. But a new awareness of the minority group characteristics of the handicapped is also required. The professional needs to draw on this awareness every time he explores with the parents the significance of their child's handicap in his education, for in a society that treats disabled children and adults as second class citizens, prejudice and discrimination have powerful effects during development. The minority group paradigm, in many other ways, can play a crucial role in improving the quality of special educational services provided to handicapped children and their parents. It can ensure that the educator devotes as much effort to understanding the sociological situation behind the child's behavior as he does to helping the child compensate for the physical limitations of his disability. It can alert the inexperienced teacher to the ease with which culturally conditioned beliefs about the nature of disability can be confused with true limitations of body and mind. It can stimulate better research into the developmental psychology of handicapped children, and it can help to foster the kind of applied research required to improve our ability to assess the child's developmental needs, to chart his progress, and to tailor individualized instructional programs to his specific strengths and weaknesses. Not least, the perspective afforded by minority education calls attention to what will probably be the central theoretical issue in special education for many years to come: the possibility that some handicapped children develop according to a healthy logic of their own.

Reference Notes

[1] For useful overviews, see C. Wright Mills, "The Professional Ideology of the Social Pathologists", in Irving Louis Horowitz, ed. *Power, Politics, and People: The Collected Essays of C. Wright Mills* (New York: Ballantine Books, 1963); Christopher Lasch, *Haven in a Heartless World: The Family Beseiged* (New York: Basic Books, 1977); and John Gliedman and William Roth, *The Unexpected Minority: Handicapped Children in America* (New York: Harcourt Brace Jovanovich, 1980).

[2] For a lengthy critique of compensatory strategies see Gliedman and Roth, *The Unexpected Minority.*

[3] Mario Fantini and Gerald Weinstein, *The Disadvantaged Child: Challenges to Education* (New York: Harper and Row, 1970).

[4] Frank Riessman, *The Inner-City Child* (New York: Harper and Row, 1976).

[5] For a research review, see Gliedman and Roth, *The Unexpected Minority.*

[6] John U. Ogbu, *Minority Education and Caste: The American System in Cross-Cultural Perspective* (New York: Academic Press, 1978).

[7] See Lasch, *Haven in a Heartless World.* See also Alison Clarke-Stewart, *Child Care in the Family: A Review of Research and Some Propositions for Policy* (New York: Academic Press, 1977).

[8] For good overviews, see Kenneth Keniston and the Carnegie Council on Children, *All Our Children: The American Family Under Pressure* (New York: Harcourt Brace Jovanovich, 1977), and Richard H. de Lone, *Small Futures: Inequality, Children, and the Limits of Liberal Social Reform* (New York: Harcourt Brace Jovanovich, 1979).

[9] Christopher Jencks *et al., Inequality: A Reassessment of the Effect of Family and Schooling in America* (New York: Basic Books, 1972), and Christopher Jencks *et al., Who Gets Ahead: The Economic Determinants of Success in America* (New York: Basic Books, 1979).

[10] This research is reviewed in Gliedman and Roth, *The Unexpected Minority.*

[11] For more extensive discussions of this point see Gliedman and Roth, *The Unexpected Minority,* and John Gliedman, "The Wheelchair Revolution," *Psychology Today,* 13, August 1979.

[12] Kurt Lewin, *Resolving Social Conflicts* (New York: Harper and Brothers, 1948).

[13] Southeastern Community College v. Davis, No. 78-711 (U.S. Supreme Court, June 11, 1979). The Supreme Court found no violation of Section 504 of the Rehabilitation Act of 1973 in the college's refusal to admit Francis B. Davis, who had a serious hearing impairment, to its registered nursing program.

[14] For a more extensive discussion, see Gliedman and Roth, *The Unexpected Minority.*

[15] See Gliedman and Roth, *The Unexpected Minority,* for an extensive discussion and full documentation of the points made in this section.

[16] Thérèse Gouin-Décarie and Monica O'Neil, "Quelques aspects du developpement cognitif d'enfants souffrant de malformations dues à la thalidomide," *Bulletin de Psychologie,* 27, No. 310, 5-9, 1973-1974, pp. 286-303 (author's translation).

[17] Gouin-Décarie and O'Neil, pp. 286-303.

Current Status in Research Relating to Model Development and Early Intervention for Young Handicapped Children

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Introduction

Programs for handicapped children were greatly stimulated by the passage of the Early Childhood Assistance Act in 1968, which established "model" programs known as the Handicapped Children Early Education Programs (HCEEP). "Models" were defined as programs based on a particular philosophical orientation, such as the Bankstreet program or Perry Preschool. The law assumed that there was knowledge available about how to establish these programs for young handicapped children, and it was also recognized that there was no consensus among educators as to the "right" model. Therefore it did not delineate the nature of a specific model, but encouraged the establishment of a variety of programs. Furthermore, the law required that a model be established in each of the fifty states, and located geographically within each state so that it could be readily accessible to other professionals wishing to learn how to establish a model program.

While many kinds of activity document the growth and refinement of these programs (DeWeerd, 1974), what is important in this paper is the great deal of research and evaluation on early childhood education for the handicapped that occurred. Much of what we know about how to plan, organize, establish, and operate a program has either been learned or refined by the involvement of personnel in these programs. There is still much to be learned, and four research institutes have been established to inquire into these problems (McDaniels, 1976). They are: the Carolina Institute, UCLA, the Kansas Institute and ETS in Princeton in collaboration with Roosevelt Hospital in New York City. However, there has been an enormous increase in our knowledge concerning infant competence and development (Horowitz, 1975; Heatherington, 1977). The findings in the field of normal child growth and development have greatly influenced our concept of infancy. The role that maturation of the nervous system plays in the stages of a child's mastery of complex perceptive and mental activities is of strong current interest (Goldman, 1976).

This paper presents an overview of what is currently known or believed about the model programs relating to effective education of impaired children. Furthermore, it will deal with what research evidence in general suggests about the appropriate times, manners, and means of such education. In the first section, themes relating to program effectiveness will be discussed. In the succeeding sections, research on early intervention and intervention programs will be explored.

Emergent Themes of Intervention Effectiveness

Structure and Organization

Several broad factors have been shown to be related to the manner and structure of a program's effectiveness. Ideally, a program should operate from a strong theoretical base, and have a planned and structured curriculum consistent with this philosophy; high-quality personnel; a system of ongoing supervision and planning; a low teacher-to-pupil ratio; and some form of parent involvement (Anastasiow, 1976, 1979; Gordon et al., 1975; Hanes et al., 1976). It would appear that an agreed-upon philosophical orientation serves the staff as the unifying value-orientation from which they operate. Staff communication is better when each member draws upon the common terminology of a given theoretical school. In addition, the philosophy serves as a heuristic tool by which staff members can generate hypotheses about children's behavior and then select strategies to facilitate learning.

Quality of personnel means the staff's knowledge of how to operate the program, their ability to observe, teach, and evaluate children, and their overall professional air of competence. It has not been demonstrated to be related to a specific level of education or training program. Highly-rated programs usually have little turnover in personnel, and their staff are enthusiastic and intellectually curious (Stedman et al., 1972). Highly-rated teachers appear to favor instructional styles which are supportive, approving, and receptive rather than adversive, dominating, and punishing (Peters, 1977). Such teachers

use goal-setting techniques with children which have been well planned and structured (Spaulding, 1978).

The superiority of one curriculum over another has rarely been demonstrated (Weikart et al., 1978; Karnes, 1973; Miller and Dyer, 1975; Stallings, 1975). Weikart et al., (1978) speculate that part of the problem in demonstrating different curriculum effectiveness lies in our lack of fine-grained instruments for measuring such skills as problem solving, creativity, and other difficult-to-define constructs (p. 95). However, teacher supervision by his/her peers, or supervision with feedback on the impact a lesson has had on the child, is to Weikart et al., (1978) a major feature of a quality program. Teacher improvement occurs when supervision includes feedback providing information on whether the lesson had the desired effect or not, as well as to how to improve the lesson if necessary, and when the teacher has an opportunity to implement improvements (McKeachie, 1976). In essence, ongoing supervision is in-service training provided to and by the program staff. Adequate time for planning following supervision is seen, in Weikart et al.'s (1978) summary, as a major reason why the Perry Preschool program had a lasting impact on the children it served.

A well-structured curriculum offers the teacher a sequence of ordered objectives and activities, and thereby allows him/her time to plan for individual lessons, rather than having to create a universe of intervention. Furthermore, with low teacher-to-pupil ratios the teacher can individualize instruction and spend more time on a lesson, a condition which has been demonstrated to be related to pupil achievement (Berliner and Rosenshine, 1977). Both a well-constructed curriculum and low teacher-pupil ratios appear, as Wittrock (1979) suggests, to allow teachers to facilitate children's attention, memory, attribution process, and development of verbal and non-verbal images (p. 10).

Parent involvement has been observed to be a vital aspect of programs rated as successful (Gordon et al., 1975; Hanes et al., 1976; Peters, 1977). This involvement varies widely across programs, and ranges from teaching parents direct skills to having them serve as members of advisory boards, attend day or night meetings, and in some cases become involved in policy decisions (Wiegerink et al., 1978).

The specific benefits of parent involvement viewed as most desirable occur when: responsibility for the child's learning is shifted to the caregiver; instruction is focused on the mother (caregiver)-child dyad; instruction is given in the home; instruction stresses the cognitive development of the caregiver rather than that of the child; instruction provides high motivation for the parent in a comprehensive family-support system (Gordon et al., 1975; Hanes et al., 1976; Peters, 1977).

Types of models

Four general types of models have been described more fully elsewhere (Anastasiow, 1977). These include a normal developmental model, a cognitive or Piagetian model, a behavioral or learning-theory model and a combination of a cognitive-learning-theory model. As stated previously, little research is available to demonstrate the superiority of one model over another. However, there is a growing concensus among psychologists and sociologists that cognitive theories are more useful in identifying and explaining complex behavior (McKeachie, 1976), while learning-theory models are more useful in the analysis of behavior skills and for lesson planning (Anastasiow, 1979). A general evaluation of the preschool-handicapped programs across models suggests that children can make gains in motor, cognitive, personal-social, and adaptive behaviors in early-childhood programs (Wynne, Ulfelder, and Dakof, 1975).

Several preschool programs have been approved for general dissemination by the Joint Dissemination Review Panel. These are:

1) UNISTAPS: A family-oriented noncategorical program for severely handicapped children, 0-5 years of age, deaf and hard-of-hearing component. Minnesota State Department of Education, St. Paul, MN 55101.

2) The Rutland Center: Developmental therapy model for treating emotionally disturbed children. Athens, GA 30601.
3) A Model Preschool Center for Handicapped Children With Professional Training, Research and Service Components. Experimental Education Unit, Child Development and Mental Retardation Center, University of Washington, Seattle, WA 98195.
4) Precise Early Education of Children with Handicaps (PEECH). Col. Wolfe Preschool Building, 403 E. Healey Street, Champaign, IL 61820.
5) The Portage Project: A home approach to the early education of handicapped children in a rural area. Cooperative Educational Service Agency 12, Portage, WI 53901.
6) Early Education for the Handicapped. Central Institute for the Deaf, 818 S. Euclid, St. Louis, MO 63110.
7) Education for the Moderate to Profoundly Handicapped: Data-based classroom for preschool handicapped children. Teaching Research Infant and Child Center, Oregon Higher Education, Monmouth, OR 97361.
8) A Statewide Program for Identification and Language Facilitation for Hearing Handicapped Children through Home Management, Ages Birth to Six (Project SKI*HI). Utah School for the Deaf, Ogden, UT 84402.
9) The ERIN Classroom/Home Programs for a Range of Special Class and Mainstreamed Handicapped Children. The Early Recognition Intervention Network, 55 Chapel Street, Newton, MA 02160.
10) An Interdisciplinary Approach to the Early Education of Handicapped Children, Ages 0-3. United Cerebral Palsy of Northwestern Illinois, Peoria Association for Retarded Children, 320 E. Armstrong, Peoria, IL 61603.

These programs all demonstrated that children made statistically and developmentally significant gains while enrolled. The models included a behavioral, a normal developmental, and a modified cognitive approach. Long-term effects of early education with high-risk children residing in poverty conditions have been demonstrated to include a reduced number of children assigned to special education classes and of children retained in a grade. In addition, children who receive such intervention show improvement in cognitive skills, particularly in the primary grades, and in general are perceived to be better able to cope with the demands of school, as measured by achievement tests and teacher ratings (Lazar et al, 1977; Weikart et al., 1978).

Age of Intervention

The most viable data regarding the appropriate age for intervention came from preschool programs for hearing-impaired youngsters. Horton (1974) found that intervention with deaf youngsters before the age of two resulted in these children's adaptation to normal classrooms, whereas deaf children who were not in intervention programs until the age of three did not make these adaptations. Northcott (1971) reports that early intervention with the deaf prevents the development of such negative behaviors as excessive body contacts, grimaces, and other stereotypic behaviors which tend to limit the acceptance of the deaf child by the normal-hearing population.

Other dramatic results have been demonstrated with the visually impaired. Fraiberg (1977) notes that when congenitally blind children are not provided with environmental stimulation to compensate for loss of sight, they develop stereotyped hand behavior, rocking, swaying, mutism, or echolalic speech. Fraiberg suggests that tactile and auditory stimulation must be initiated with the visually impaired during the first year of life. Untreated until the age of six, a deaf/blind child will assume strong maladaptive behaviors. Fraiberg (1977) states that the behavior patterns of the untreated blind child were so typically uniform that brain damage and/or infantile autism was often a suspected etiology of

these children. Blind babies appeared to be not emotionally bonded or attached to their mothers. However, Fraiberg feels that insufficient stimuli in tactile-kinesthetic-auditory functioning in the early years of life accounted for the bizarre behaviors associated with the blind.

It is generally recommended among professionals that intervention begin early in the child's life. The data, however, are not definitive as to the critical time to begin treatment. The argument by Clarke and Clarke (1976) that much can be done for an impaired child later in development misses the point that early intervention might accomplish much more, as in the case of the deaf and blind.

Some of the strongest evidence of the impact of early stimulation comes from inferences from the longitudinal studies discussed below, and from some recent animal research. The animal research will be discussed first.

Goldman (1976) damaged the cortical area (orbital prefontal cortex) of seven-month-old monkeys. This area of the brain is known to be associated with the ability to perform delayed-response tasks. The monkeys were able to perform such a task before the operation, but following the operation they were no longer able to do so. Goldman was interested in whether re-training would lead to the damaged monkeys' re-learning of the delayed-response task, and if by extensive training another area of the brain could take over the task. One group of monkeys was trained for an extensive period between their first year and year-and-a-half of life. At no time during training were they able to perform the task. However, at the age of one-and-a-half, when another area of the brain matured, they could perform it. A second group of damaged monkeys was not trained until they were one-and-a-half years of age. When this area in the brain had already matured. This group was trained until they were two years of age, but never regained their ability to perform the delayed-response task, even after 2,000 trials at the age of two. Recovery of function is, in the Goldman study, related to the experience, and not to the maturation of other brain structures alone. "Whether such test experience promotes recovery of function through the development of specific learning or simply through a generalized 'enriching' of experience is not known" (Rudel, 1978, page 200). However, the finding supports the hypothesis that experience did promote the recovery. This finding is of major importance when one considers that some brain-damaged children exhibit potential for recovery of some functions as they grow older (Goldman, 1976). Goldman's data suggests that what may appear to be unsuccessful training at one stage of development might be critical at a later stage if these children are to recover.

Environmental stimulation is closely tied to full maturation of functions. Normal seeing chimpanzees raised in the dark for a period of time fail to see when brought into the light. White rats raised in a stimulating environment in the first days of life have larger brains than those raised in a deprived environment. Kittens carried around a room on a moving carousel fail to make the depth perceptions that kittens who moved through the environment on their own were able to make easily (Rudel, 1978). It has been clearly demonstrated with animals that early experience and stimulation modify the brain in terms of its size, structure, and functioning (Chall and Mirsky, 1978).

It is assumed that similar principles hold for the human central nervous system. There is abundant anatomical and behavioral evidence to indicate that if neural cricuits are not brought into play at certain critical times of development, they may never be capable of functioning (Mac Lean, 1978, page 341).

The developing human nervous system, if damaged, has a great potential for recovery or for the damaged functions being "taken over" by other structures (Rudel, pp. 306-307). However, this recovery and takeover are both related to training and/or direct experience, and to the age of the training.

The human brain does not add brain cells after the second year of life. The major additions after the second year, resulting in full size at fifteen to sixteen years of age, are a function of the extension and branching of axons and dendrites of brain cells, the myelin sheath, and increased arterial blood supply. These increases do not appear in a gradual sequence but make their appearance in five growth spurts (Epstein, 1978), and these are accompanied by dramatic changes in the intellectual and social functioning of the infant. The first spurt is at two to three months and is accompanied by the appearance of the

social smile and changes in sleep and brain-wave patterns (Emde et al, 1976). The second is at six to eight months and signals the appearance of "stranger anxiety" or infant fear of strangers. The third spurt is at eighteen to twenty-four months, a time when language and speech accelerate rapidly. (The next brain-growth spurts accompanied by bio-behavioral shifts occur at six to eight years of age, ten to twelve, and fourteen to sixteen, and due to space limitations will not be detailed here.)

It is suspected that the spurts signal maturation of structures and are either periods of rapid learning (Epstein, 1978) or, as we have seen above, periods when previous learnings make their appearance in child performance (Goldman, 1976). This paper takes the latter posture. The inference that can be drawn from research on the impact of experience on brain development in that stimulation or intervention should occur before the maturation of structures. In addition, the agent and environment in which stimulation occurs is critically important.

Agent and Environment of Stimulation

Several longitudinal studies have demonstrated rather conclusively that what a caregiver (usually the mother) does with the infant can either facilitate or retard development (Werner et al, 1971; Broman et al, 1975; Neligan et al, 1974; Elardo, Bradley, and Caldwell, 1975, 1977). The findings of more than sixty studies report a consistent pattern of child-rearing attitudes which facilitate the child's IQ and achievement development (Martin, 1975). These attitudes include moderate use of warmth, low use of physical punishment, high use of verbalization, a moderate response to the child's needs, and pressure for the child to make age-appropriate developmental adaptations. Caregivers who respond to the child, verbalize with the child, and present a stimulating set of experiences, such as providing toys in the home and taking the child out of the home, have children who learn to speak more rapidly (Nelson, 1973). In addition, caregivers who provide these experiences in a warm, supporting environment, and encourage exploration and independence, have children who not only progress more rapidly in language development but also have higher IQ scores at age three (Elardo, Bradley, and Caldwell, 1975, 1977). Not only can the caregiver facilitate growth and development, but through the same practices which facilitate development he can offset traumas associated with perinatal stress (Werner et al, 1971). In the Werner et al study, mothers of low socioeconomic status who used negative child-rearing practices (high physical punishment, low use of warmth, low verbalization, and ignoring of the child; or high warmth, high physical punishment, and low pressure for developmental attainments) had children who attained low IQs and did poorer in school achievement tests and teacher ratings. The environment appears to hold the potential for minimizing or maximizing early developmental difficulties. Middle socioeconomic status and caregiver attitudes can dissipate the effects of such perinatal stress complications as anoxia or low birth-weight. Poor social environmental conditions and negative attitudes tend to amplify the effects of such early complications. Thus, the set of variables which most predicted success in school (achievement, IQ, and teacher rating of adjustment) in spite of perinatal stress were the caregiver child-rearing attitude and socioeconomic status variables.

A Transactional Approach To Model Development

The basic argument presented here is that the social environment does much to help the human organism realize its genetic potential. Development is a transactional process involving the integrity of the organism, the environment, and the skills of the agent who does the teaching in the environment (Sameroff and Chandler, 1975). The infant's central nervous system is flexible enough to provide alternative structures in the case of sensory or physical impairments. However, the impairment, whether known or suspected, must be identified and treated before the maturation of the alternative structures can occur, and it is persons in day-by-day interaction with the infant who provide the treatment which tends to offset the impairment. That is, the infant is seen to be synergistically interactive with the environment (Beckwith, 1976). This transactional view owes much to Werner et al's (1971) research, and

has been well defined by Sameroff and Chandler (1975). It stands in contrast to linear and unidirectional models, such as that of Gesell (Anastasiow and Stengle, 1977).

In this author's opinion little research has been conducted to answer Beckwith's (1976) question of "How, in what ways, and with what relative effectiveness for what age infant do specific dimensions of the mother-infant interaction operate; which effects persist, at what later age, and how are effects modified or attenuated by intervening experience?" (page 119). What we can say is that it appears that caregivers influence the genotype by influencing the level of the child's developmental attainment through setting the intellectual level of the environment (Scarr-Salapatek, 1976). They appear to do so in a variety of known and unknown ways: by responding to the infant's biologically programmed social smile at three months and by holding "conversations" with their infant (Schaffer, 1977); by learning to talk "babyese" or baby talk (Snow and Ferguson, 1977); by establishing a bond or attachment with their infant during the first months of life (Bowlby, 1969).

If caregivers of normal infants have such a pronounced effect on the attainment of his/her genetic potential, consider the impact that parents of impaired children can have on the development of their infants. As Mercer (1971) and Carlson (1976) stress, impaired children are only handicapped if the environment makes demands upon them that they cannot perform because of their impairments. Caregivers who modify their demands and the environment to meet the state of the child facilitate development.

Summary

What is clear in the literature, whether one adopts an early-intervention stance or a strong life-span approach, is that the social environment of the child facilitates or debilitates development. To argue that early deficits can be treated later is to miss the significance of the Werner et al study as to how social class and caregivers' attitudes mediated such traumas as anoxia and breech birth during the first year of life and continuously afterwards.

Intervention affects the total life-space of the child and, as our review suggests, focuses on the agent of development—the caregiver (usually the mother). Intervention which does not include the caregiver is usually ineffective (Bronfenbrenner, 1975), while intervention which focuses on the parent is usually more effective.

The life-span view considers early intervention important but not sufficient (Goldhaber, 1979). Certainly we agree with that stand. Early intervention, to be effective, must be continuous. But continuity does not diminish the impact on a child's life that may be had by treating him early.

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Current Status of Personnel Training for Early Intervention Programs

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Introduction

The purpose of this paper is to examine what is currently being done in personnel preparation for early intervention programs. In exploring this topic, four major systems involved with providing services to handicapped children are examined: the National Diffusion Network, the Bureau of Education for the Handicapped, Project Head Start, and Parent-Child Development Centers. It should be noted that the severity of the handicapping conditions of the children served by these programs ranges from high-risk or developmentally delayed to severely/profoundly involved.

As the training efforts of each system are explored, attention is given to the approach, content, target audience(s), and source(s) of funding. Before these systems are described, however, the various limitations of the paper are cited. In the final section of the paper, a general summary is provided followed by recommendations for future training efforts.

Limitations

1. Although four key systems concerned with training are examined in the present paper, this review is in no way exhaustive. These systems were chosen because of the broad scope of preschool services they provide. Other types of training efforts exist, such as that provided to preschool program staff in local education agencies by Regional Resource Centers in states mandated to serve preschool handicapped children, and localized training provided to day care staff in the state of North Carolina by the Day Care Technical Assistance and Training System at the University of North Carolina, Chapel Hill. Additionally, this paper is limited to systems that have national recognition in early education services, and does not examine training provided by private consulting agencies and the like. Finally, the programs described herein are ones on which information was readily available from primary funding sources.

2. The nature of programs serving preschool handicapped children encourages ongoing training of program personnel, both preservice and inservice. This fluidity makes the area of training a concept not easily captured, and one that does not lend itself to more comparative and analytical treatment, as do other more stable, intrinsic concepts. Thus, the information here presented is in the context of description only.

3. The training programs presented under the topic "Teacher-Training Programs" represent those identified during a national survey conducted during 1976-77, and focus mainly on models known as competency-based programs. Hence, master's level training programs developed since that time are not discussed here. This omission is due in part to the unavailability of a composite listing of programs from major funding sources. Following completion of national surveys being conducted by the Council for Exceptional Children and the Educational Resources Information Center on Early Childhood Education, it is hoped that more current and up-to-date information will be available.

The National Diffusion Network

One major system that ultimately serves as a source of training for personnel in early intervention programs is the National Diffusion Network (NDN). Funded by the U.S. Office of Education (USOE), the goal of the four-year-old system is to help local educators solve pressing problems by offering them proven educational alternatives.

The establishment of the network can be traced back to 1965 when Congress passed the Elementary and Secondary Education Act. By providing funds for developing programs to meet the educational needs of children, especially those from low-income families, Congress initiated the movement for improving the education of all children. In the years that followed, many programs were developed, several of which were effective at their own local sites. For local school systems everywhere to share the successes of these programs, the NDN system was developed.

The NDN system offers proven educational alternatives. Although many of its programs provide services to the school-age population, the system also consists of programs that serve preschool handicapped children.

To facilitate the operation of the network, two participant groups exist—State Facilitators (SFs) and Developer/Demonstrators (D/Ds). SFs, located in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands, are attuned to the needs of the state's school districts. They help to link the state's schools with D/D projects that have succeeded in solving similar types of problems, and are careful to match the needs of the local schools with the competencies of exemplary programs.

Some 120 exemplary programs are now being supported as D/D's by USOE. These programs are models which have been approved by the Joint Dissemination Review Panel (JDRP), a group of representatives of USOE and the National Institute of Education. The panel's purpose is to ensure that the benefits claimed for those served by any federally-funded education program are reliable, valid, and educationally meaningful, and that program intervention and its effects can be reproduced at other sites (Boyd and Vandiviere, 1978).

For 1978-79, 64 JDRP programs providing services to preschool handicapped children have been approved as D/Ds. Eleven of these programs are cited in Table 1, along with a brief description of each project's training focus. During the course of these programs' work with interested sites, federal funds are provided so that D/D staff can render on-site training. Each adopting site receives training and coordination assistance to assure that the key program elements will actually work in the new location.

The Bureau of Education for the Handicapped

The Bureau of Education for the Handicapped (BEH), funded by the U.S. Office of Education, is another organization whose efforts result in a broad spectrum of personnel preparation for early intervention programs. BEH has an organizational structure composed of four divisions, two of which are discussed here: the Division of Innovation and Development—Early Childhood Section, and the Division of Personnel Preparation.

The Division of Innovation and Development–Early Childhood Section

Within the Division of Innovation and Development is the Early Childhood Section which administers the Handicapped Children's Early Education Program (HCEEP). The purpose of the HCEEP is to assist in developing and implementing innovative and experimental programs for young handicapped children, birth to eight years of age, and their families. The HCEEP is authorized by Title VI, Part C of the Education of the Handicapped Act (PL 91-230).

The HCEEP network comprises five types of programs. The training efforts of three of these programs are discussed: HCEEP Demonstration projects, HCEEP Outreach projects, and the State Implementation program.

HCEEP Demonstration Projects

For 1978-79, 127 Demonstration projects are funded nationwide. The goal of this network of projects is the development of exemplary models for demonstration and dissemination during their three-year grant period. Activities which characterize the network include services to children, services to parents, staff development, program evaluation, and demonstration and dissemination. Of these categories, those activities that focus more directly on training are: services to parents, staff development, and demonstration/dissemination.

Across projects, training within the services-to-parents component varies greatly. Examples range from weekly postnatal mother/infant classes carried out in the pediatric unit of the Cincinnati General

Table 1

Training Efforts of National Diffusion Network Programs Encompassing an Early Childhood Focus*

Project Title and Location	*Training Activity*
Developmental Play (DP): A Validated Pupil Personnel Services Demonstration Project—Florida	A training program for adults who wish to work with young children in a relationship-focused activity-based intervention program.
project ERIN: Early Recognition Intervention Network—Massachusetts	Coordinated training programs and service delivery systems aimed at harnessing the learning environment/materials/adult intervention resources to teach young children with a range of special needs.
Exemplary Center for Reading Instruction (ECRI)—Utah	An inservice program for teachers of students at all ability levels in reading and language skills, with expectations of 95-100% mastery.
Family Oriented Structured Preschool Activity (Seton Hall Program)—Minnesota	A program that prepares the parent to be the child's first and most significant teacher.
project Home Base—Washington	A program for "helping parents teach their own."
Individualized Bilingual Instruction (IBI) [formerly Training Migrant Papaprofessionals]—Washington	Training system to prepare bilingual adults to teach reading, math, and oral Spanish and English to preschool age through third-grade children.
Parent Readiness Education Project (PREP)—Michigan	An early-intervention project for academically high-risk preschool children, in which parents attend classes to learn to become effective change agents for their own children; and high school students learn pre-parenting skills while working with children.
Program for Children with Down's Syndrome [formerly A Model Preschool Center for Handicapped Children: Down's Syndrome Programs]—Washington	A program designed to accelerate and maintain developmental gains of children with Down's syndrome; to give help and training to their parents; to develop a transportable model; and to provide an exemplary demonstration program.
Public School 243/Bank Street College Follow Through Program—New York	A project focusing on the total development of the child *and* his or her family through instruction, staff development, parent involvement, health and nutrition, and social and psychological services.
Richmond (Virginia) Follow Through Resource Center—Virginia	A program teaching parents to establish a home environment that promotes active participation in their children's education, and to augment their children's self-esteem and learning abilities.
the Rutland Center—Developmental Therapy Model for Treating Emotionally Disturbed Children—Georgia	A community-based psycho-educational facility that offers a developmental curriculum to severely disturbed or autistic children from birth to 16 years, their parents, and teachers.

* Excerpted from *Educational Programs that Work*, U.S. Office of Education, Department of Health, Education and Welfare, Fall 1978, pp. 4-1 through 4-3.

Hospital to individual parent-training sessions focusing on the implementation of an individual education program at the Family, Infant and Toddler Project in Nashville, Tennessee.

Training within the staff-development component is also very idiosyncratic. Activities may revolve around refining staff skills in instructional approaches, as in the Preschool Demonstration Project, San Jose, California, or the focus might be on enhancing staff skills for programmatic operations, as in the Louisville School for Autistic Children in Kentucky.

In implementing the demonstration and dissemination component, Demonstration projects have developed a variety of print and media products. Video tapes are used to teach assessment techniques, observation skills, and behavior-management strategies. Along with a slide-tape production, training manuals are usually produced as a means of providing a tangible training item to share with other programs.

HCEEP Outreach Projects

Fifty-nine (59) Outreach projects are funded for 1978-79. These programs have two major purposes: (1) to stimulate increased high-quality services for preschool handicapped children and their families; and (2) to develop effective Outreach models. Unlike the HCEEP Demonstration projects, Outreach models are funded to provide assistance to other agencies in six general areas: increased awareness, product development and distribution, stimulating state involvement, *training,* and other specific consulting activities. With regard to training, Swan (1978) indicated that Outreach efforts may include "short-term training to groups, longer practicum-internship placements, and working with university training programs to utilize model components in early childhood courses" (p. 13).

During 1979-80, the nature of HCEEP Outreach will change. With a new focus as HCEEP Model-Outreach, much more emphasis will be placed on providing assistance to sites particularly in the areas of services to children and services to parents. Less emphasis will be placed on awareness, product development and distribution, state involvement, and other specific types of consulting (Swan, 1978).

The State Implementation Program

A third endeavor administered through the Early Childhood Section of BEH is the State Implementation program. Known as the SIG (State Implementation Grant) program, this consists of a two-year grant awarded to state education agencies to assist in the implementation of statewide plans for early childhood/special education.

The activities of a SIG vary from state to state. However, program activities generally fall into five topical areas: program development/management, evaluation, *personnel training,* interagency coordination and communication/dissemination. An early childhood person, housed in the state education agency, usually manages implementation of the grant.

Through the SIG program, states have been and continue to be engaged in many training activities. Table 2 summarizes the efforts of several states over the past three years of the program. As can be seen, training encompasses an array of activities including training administrators in viable approaches to working with parents, refining the skills of regular and special education teachers for instructional purposes, and training local assessment teams in appropriate assessment procedures. In addition to addressing specific topics of interest, several states have conducted statewide awareness training workshops, especially for administrators. Although a significant amount of statewide training in early childhood/special education is the result of the SIG program, other resources often are tapped to maximize the effort.

Table 2

Personnel Training: State-Level Efforts*

State	*Training Activity/Material and Focus*	*Audience*	*Funding Source*
Colorado	A. Local team training using a process model—four institutes held: Colorado Process Model, Child Find, Program Planning, Parent Involvement. Manuals were developed for each institute and follow-up training is provided.	A. Local service providers	A. State Implementation Grant
	B. Parent hot line to SEA: installed to assist in parents' information needs.	B. Parents	B. State Implementation Grant
	C. Statewide parent conference: rationale for parent involvement, parent involvement models, child development, working with parents, parenting techniques, parent groups, parent resources.	C. Parents	C. State Implementation Grant
District of Columbia	Teacher training in classroom management, mainstreaming, gross motor development, language development.	LEA teachers	State Implementation Grant
Illinois**	A. Development of a manual of recommended procedures and practices for early childhood education.	A. Early childhood service providers	A. Title VI-D and Incentive Grant
	B. Spring 1978 HCEEP consortium Training Seminar: legislative trends, child find, delivery systems, program evaluation.	B. Early childhood service providers	B. Title VI-D
	C. Development of replication manual.	C. Local EC training personnel	C. Title VI-D
	D. Conference on interagency agreement writing and maximum use of P.L. 94-142.	D. Head Start and department of education personnel	D. Incentive Grant
Indiana	A. Workshops for kindergarten teachers: based on topics identified by needs assessments.	A. Kindergarten teachers	A. State Implementation Grant
	B. Five topical conferences for special education directors based on commonly identified needs.	B. Special education directors	B. State Implementation Grant
	C. Statewide symposium: Early Education for Handicapped Children—Issues, Trends and Strategies.	C. LEA pre-kindergarten and primary teachers, administrators, ancillary personnel	C. State Implementation Grant

State	Training Activity/Material And Focus	Audience	Funding Source
Kansas	A. Four regional awareness conferences: based on topics identified by needs assessments.	A. Special education directors: LEA, Head Start, DD, social workers; public health nurses; teacher training personnel; parents	A. State Implementation Grant
	B. One multidisciplinary assessment conference.	B. All of the above except parents	B. State Implementation Grant and Title VI-D
Louisiana**	A. Inservice training: normal child development, feeding and toileting, curriculum development, child management, speech and language development, recommended procedures manual for providing services. B. Inservice and preservice training: classroom and multidisciplinary assessment; classroom and adaptive equipment for severely handicapped. C. Weekend/part-week training: programming for autistic and multiply handicapped children. D. 1979-80—eight Regional Parent Centers provide information, training, and referral services.	A. Teachers and paraprofessionals of Head Start, day development centers; parents & administrators invited B. Same as "A" above plus assessment teams C. Same as "B" above D. Parents	A. and/or B. State Implementation Grant C. State funds through Developmental Disabilities D. Incentive Grant
Maine	Training sessions (currently being planned for Spring '79): contracted services with Maine Children's Resource Center to upgrade screening and assessment skills of project personnel at local level.	Any and all local teachers and paraprofessionals	State Implementation Grant
Massachusetts**	A. Three sessions with college teachers each year to collaborate and work together in early childhood efforts. B. RFP developed for 1979 summer inservice training of LEA teachers.	A. SEA early childhood personnel & college teachers B. LEA teachers	A. Incentive Grant B. Incentive Grant
Nebraska	A. Parent Newsletter B. Toy library C. Three parent conferences (one developed by parents for professionals) D. Monthly inservice training for private providers (75 sessions in 2 years) E. Statewide conference for private providers. (Private providers have the opportunity to participate in public school inservice training).	A. —E. All private and public service providers	A. —E. State Implementation Grant

State	*Training Activity/Material And Focus*	*Audience*	*Funding Source*
New Jersey	Inservice training: adoption of High Scope Curriculum	LEA teachers	State Implementation Grant
New York	A. Direction Centers: provide information, materials, services to families.	A. Parents/families	A. State Implementation Grant funds administration of centers; Incentive Grant funds direct services
	B. Training on how to work with parents: video tape sessions on assessment, parent effectiveness training.	B. Direction Center directors	B. State Implementation Grant and Incentive Funds
North Carolina	A. Statewide parent conference: use of state-developed parent materials, behavior management, child's self-esteem B. Three administrators conferences: rationale for early programming for young handicapped. C. Parent workshop manual: training for parent leaders	A. Local parents B. LEA administrators C. Local parents	A., B. & C. State Implementation Grant and Incentive Funds
Oregon***	Inservice training: based on child needs data, i.e. child change data from local preschool programs.	Local teachers	State Level Funds
Pennsylvania	Three regional workshops: presentation of a framework for establishing interagency teams; mechanisms for developing interagency agreements.	Local program personnel: Head Start, day care, intermediate units, county mental health/mental retardation centers. EPSDT, parents.	State Implementation Grant
Puerto Rico	Inservice Training: curriculum and assessment	LEA teachers and assessment teams	State Implementation Grant
Rhode Island	A. Screening and assessment training B. Materials for screening and assessment	A. & B. Community service providers	State Implementation Grant

State	Training Activity/Material And Focus	Audience	Funding Source
South Dakota**	Summer Early Childhood Institute (1978): —individualizing instruction —creativity in children —gross/fine motor skill development —parent training —program evaluation —application of child development to exceptional children —working with advisory boards, child advocates and parent groups	Regular and special education, speech therapists, Title I, elementary principals	Title VI-B and VI-D
Tennessee	Interagency task force: identify inservice training needs across agencies	Local and state level service providers	State Implementation Grant
Virginia*	A. Project IMPRINT (Inservice Model for the Preparation of Instructional Teams): "assist school divisions with comprehensive educational programs for preschool handicapped children. . . " Workshop topics are: —child identification, —assessment and diagnosis, —individual educational programming —coordination of community resources, —organization and implementation of programs, —evaluation of program effectiveness. B. Regional Technical Assistance Centers: provide fieldbased technical service including information, consultation, demonstrations, and related activities.	A. Teachers, administrators, supervisors, parents, volunteers, paraprofessionals, support personnel, interdisciplinary teams. B. LEA teachers	A. Title VI-D B. Incentive Grant
Washington	Five Regional Technical Assistance Centers: each center works with a university from its respective area to offer inservice training workshops, outreach field assistance, evaluation activities, and general technical assistance. Training activities include assessment, program planning, parent involvement, behavior management, medical-physical problems, community resources, legal issues, infant stimulation, and related topics.	Any and all preschool personnel: teachers and administrators from Head Start and LEA, developmental center staff, paraprofessionals and professionals from related disciplines.	State Implementation Grant
Wisconsin	A. Teacher Training Institutes: based on topics identified by needs assessments	A. LEA teachers; DD personnel, infant and toddler teachers invited	A. State Implementation Grant

B. Preschool training modules:
—screening
—assessment
—curriculum strategies
—instructional materials
—parent involvement
—training paraprofessionals
—interagency
—administrative aspects
—professional growth
—instructional activities

B. LEA teachers

B. State Implementation Grant

*Training efforts cited include those supported by State Implementation Grants as well as other support avenues.
**States that have or have had a State Implementation Grant but have used other support for training efforts
***Oregon has not had a State Implementation Grant but has been involved in state-level training.

Along with the SIG program, another effort taking place in some states is early childhood consortium activity. The states of Virginia, California, Colorado, and Illinois each have formed a consortium within their respective states. These consortia are composed of the SIG program and the HCEEP Demostration and Outreach projects. They are organized to stimulate high-quality early intervention through: a statewide network of training centers (California); the co-sponsoring of early childhood training seminars (Illinois); conducting a statewide needs assessment of training interest (Colorado); and producing a service directory that describes assistance available from the Demonstration projects (Virginia).

Much state-level training is being conducted in early childhood/special education. And, as states continue to become involved in programming for young handicapped children, it is hoped that the scope of activity will continue.

The Division of Personnel Preparation

Three key categories of funding in the Division of Personnel Preparation support the training described in this section. These three categories are: (1) funds for teacher training—preservice and inservice; (2) funds for volunteers training (parents)—preservice and inservice; and (3) funds for "special projects." An example of the kind(s) of training occurring within each category is examined.

*Teacher-Training Programs**

The impetus for teacher-training programs in early childhood/special education began during the early 1970's and, over the last few years, several programs have been established. Apart from the recognition of the benefits of early intervention, one primary force that has stimulated this development was the passage of Public Law 94-142, the Education for All Handicapped Children Act of 1975. Under this mandate, state education agencies are responsible for seeing that a free, appropriate education is provided to all handicapped children who are between the ages of 3 and 18. In helping to ensure this demand, colleges and universities are offering teacher-training programs.

Investigations to determine the number and nature of current teacher-training programs for early childhood/special education surveyed a number of colleges and universities nationwide. The survey was limited to master's-level training since most programs are limited in this manner. Over 60 training programs were identified (see Appendix A for a listing of the program locations). Fifteen of the programs submitted descriptions of their training. Analysis of the descriptions overwhelmingly verified the opinion of Stewart, Denson, and Stone (1976), that most of the programs developed over the last few years are competency-based models. A competency-based model is a program which specifies the behaviors (competencies) to be demonstrated by a student, makes explicit the criteria to be applied in assessing the students' competencies, and holds the student accountable for meeting those criteria (Cooper and Weber, 1973).

With regard to the 15 programs that provided a program description, an analysis was conducted to determine the specific nature of their competency-based models. This comparison, conducted by Berkeley and Miller (1977), was limited to classroom performance competencies. Behaviors were specified in five categories:

A. areas of general competence;
B. assessment, objectives, and curriculum planning;
C. the teaching/learning situation;
D. evaluation and record keeping;
E. parent involvement

*Most of the training programs that are in operation receive funding from the Division of Personnel Preparation.

Table 3 provides a compilation of the competencies by category and also gives the frequency of occurrence for each competency. As can be seen, several of the competency categories are shared by a significant number of training programs. If a similar analysis were conducted across all competency areas for each of the programs identified, similar findings probably would be found, although unique and interesting competencies exist within individual models.

Presently, enthusiasm and motivation to develop competency-based teacher-training programs still exist. As services continue to be provided for preschool handicapped children, appropriate training programs will continue to be important.

Volunteers Training Programs (Parent-Training Efforts)

A second category of training programs receiving funds from the Division of Personnel Preparation involves volunteers. This group includes parents among its representatives, and two parent training programs are described briefly. The two programs are: the Parent Education Advocacy Training Center in Virginia and the Parent Advocacy Coalition for Educational Rights in Minnesota.

The Parent Educational Advocacy Training Center, located in Alexandria, Virginia, has as its goal the development of a training model for parents concerning their rights and responsibilities under Public Law 94-142, the Education for All Handicapped Children Act of 1975. To that end, the project has implemented a "Weekend" training model, hosting parent training sessions over the weekend. At present approximately 160 parents are being trained.

The Virginia program has a comprehensive model which emphasizes competency building. It attempts to strengthen parents' knowledge, attitudes, values, and skills with regard to their right to advocate for their children. Parent competencies stressed by the program include:

—developing data-based information on their children through learning how to observe children in various settings;
—playing an active role in their children's evaluation, from assessment through placement;
—decoding school evaluation records;
—developing goals and objectives for their children's Individual Educational Programs (IEP);
—scrutinizing a "least restrictive environment" placement;
—monitoring their children's IEPs; and
—demonstrating an understanding of "due process."

In its role as a training agency, the program also provides parent consultation.

The Parent Advocacy Coalition for Educational Rights, based in Minneapolis, Minnesota, is assuming a statewide training effort through a coalition of agencies located in Minneapolis. The program serves approximately 500 parents. Its primary training goal is awareness and motivation to prompt parents to advocate at the local education agency level regarding programs (including preschool) and Public Law 94-142. A unique characteristic of the program is its use of parents as trainers. Similar to the Virginia project, the Minneapolis agency is looking toward utilizing itself in the consulting role.

Special Projects

Approximately nine percent of the funds in the Division of Personnel Preparation is allocated to a segment called "special projects." In a conversation with William Peterson, Project Officer, Division of Personnel Preparation, Western Region, Special Projects, Mr. Peterson named five projects funded under this umbrella. They include a developmental therapy program at the University of Georgia, Athens; a psychomotor training project in Maryland; a training program for pediatricians at Children's Medical Center in Boston; an inservice program at the Research Institute for Educational Problems, Incorporated, in Cambridge; and a program concerned with developing materials for training

Table 3

Teacher Competencies for Early Childhood/Special Education Training Programs*

(Compiled from information provided by 15 colleges and universities)**

The competencies cited below pertain to the classroom setting. They have been categorized as follows:

A. Areas of General Competence
B. Assessment, Objectives, and Curriculum Planning
C. The Teaching/Learning Situation
D. Evaluation and Record Keeping
E. Parent Involvement

Competency	*Frequency of Occurrence*
A. Areas of General Competence	
1. Enthusiasm when working with children	11
2. Confidence and poise in establishing and maintaining the learning environment	12
3. Patience and understanding toward children	11
4. Patience and understanding toward co-workers and other professionals working to enhance the child's progress	13
5. Responsibility in general classroom operations, including safety.	10
6. Sensitivity to the effects of physical conditions of the classroom on learning	9
7. Understanding the establishment of preschool programs.	3
8. Understanding the staffing needs of preschool programs.	3
9. Knowledge of national literature, publications, and nationally-known preschool projects and models.	3
10. Knowledge of child development, and of the effects of handicapping conditions no normal development.	13
11. Understanding of advocacy for the educational rights and priviledges of exceptional children and youth.	3
12. Ability to train and supervise paraprofessionals, volunteers, and students	4
B. Assessment, Objectives, and Curriculum Planning	
1. Recording and interpreting teacher/child interactions.	11
2. Assessing a child's strengths and weaknesses in establishing an instructional level.	15
3. Using the assessment data profiles in setting up individual prescriptive educational programs.	15
4. Initiating interdisciplinary evaluations and assessments.	3
5. Using the task analysis process in establishing instructional sequences.	9
6. Writing instructional objectives based on assessment data.	15
7. Initiative and resourcefulness in curriculum planning.	10
8. Selecting, administering, and using information from standardized and nonstandardized measurement tools.	11
C. The Teaching/Learning Situation	
1. Teaching and maintaining attending behavior with one child.	10
2. Teaching and maintaining attending behavior with a group of children.	9
3. Developing teaching procedures which demonstrate the arrangement of antecedent events, response differentiation, and consequence strategies.	14
4. Using appropriate positive reinforcement	11
5. Using strategies of modeling, cueing, prompting, and fading.	9
6. Using appropriate and consistent consequences to decrease inappropriate behaviors.	11
7. Using baseline and probe data on associated behavior.	7
8. Teaching toward the generalization of specific skills.	9
9. Individualizing instruction within a group situation.	9
10. Selecting, using, and adapting teaching materials. (Commercial as well as teacher-made).	15
11. Using instructional media. (Audio-visual, projected, and printed).	12
D. Evaluation and Record Keeping	
1. Improving teaching skills through self-evaluation, goal setting, and planning learning activities.	9
2. Evaluating daily lessons and activities for recording pupil progress and modifying teaching strategies.	12
3. Developing records and information systems	9
4. Self-evaluation of teaching performance through the use of video tapes.	4
5. Program evaluation skills.	3
E. Parent Involvement	
1. Implementing a program for parents.	15
2. Assessing parental needs for co-operative goal setting in the child's program or parent involvement activities.	12
3. Contacting parents on a regular basis.	10
4. Providing training for parents.	10
5. Visiting and counseling parents in the home.	3

*Compiled by T. R. Berkeley and P.S. Miller, Technical Assistance Development System, Frank Porter Graham Child Development Center, University of North Carolina, Chapel Hill, 1976-77.
**See Appendix B for a listing of the 15 colleges and universities.

professionals and paraprofessionals in the area of hearing impairments at the Central Institute for the Deaf in St. Louis. With the exception of the training program for pediatricians, all of these projects are basically inservice programs for teachers in local education agencies. The very nature of their training efforts makes them unique in their special contribution to services for young handicapped children.

As can be seen, the array of training endeavors funded by BEH is vast. As the field of early childhood/special education continues to expand and become even more defined, training efforts of this magnitude must be continued.

Personnel Preparation in Project Head Start

Project Head Start was established in 1965 by the Office of Economic Opportunity as part of the federal government's "war on poverty." As a comprehensive program for preschool children from low-income families, its ultimate goal is to assist children in becoming more successful participants in society.

In the years that followed Head Start's inception, it became increasingly clear that since it was the nation's largest preschool program, more attention should be given to providing services to the handicapped. Head Start had always served the handicapped to an extent, but it was felt that a more proactive stance should be taken in identifying and recruiting the handicapped. In 1972, more concrete action was taken when Congress passed Public Law 92-424, which made services to the handicapped mandatory in Head Start. This law required that not less than 10% of the Head Start enrollment opportunities *nationwide* be made available to handicapped children. Going a step further, in 1975 Public Law 93-644 (the Head Start, Economic Opportunity, Community Partnership Act of 1974) was signed. This law retained the 10% enrollment mandate, but it stipulated that beginning Fiscal Year 1976 no less than 10% of the enrollment opportunities in each *state* be available to handicapped children (LaVor, 1972).

Since the passage of these two laws Head Start programs have been involved in several efforts to serve handicapped children. A paragraph taken from *The Status of Handicapped Children in Head Start Programs* (1979) summarizes some of these:

> Under the Education for All Handicapped Children Act of 1975, (P. L. 94-142), each state's allocation figures are based on the number of handicapped children, 3-21, currently being served. As a major provider of services to preschool handicapped children, Head Start program personnel worked with local education agencies in many places to insure that the number of children who had been professionally diagnosed as handicapped and who were receiving Head Start services were included in the state count. In addition, Head Start programs coordinated their searches for unserved handicapped children with the statewide "Child Find" efforts required under P.L. 94-142. Head Start personnel have also taken steps to increase program ability to use other resources such as Medicaid, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. (p. 3)

The active involvement of Head Start in serving the handicapped has spurred local programs to seek additional training in this area. In addition, many teachers and paraprofessionals have begun to channel their training into a competency-based system known as the Child Development Associate (CDA) program. (Since many Head Start sites were already involved in CDA training, combining the two areas seemed most feasible). The CDA program is a credential award system through which child-care workers can demonstrate their ability (competency) to work with preschool children in a center-based setting. After completing an individualized competency-based program, the candidate is confirmed in his abilities through the award of a CDA credential by the Child Development Associate Consortium in Washington, D.C.

Although at present the CDA program has not specified competencies in the area of early childhood/special education, the current set of competencies can be applied to programming for preschool handicapped children. During the course of a candidate's individualized training, the

necessary adjustments can be made to bring concepts and skills in early childhood education into closer relation to programming for the handicapped.

What are the competency areas of the CDA program? As cited by the CDA consortium, the six competency areas are:

—Establishes and maintains a safe and healthy environment;
—Advances physical and intellectual competence;
—Builds positive self-concept and individual strength;
—Promotes positive functioning of children and adults in a group;
—Brings about optional coordination of home and center child-rearing practices and expectations; and
—Carries out supplementary responsibilities related to programs.

Each competency area is further elaborated and defined by the Consortium.

In response to the growing recognition that Head Start staff must be appropriately trained to serve handicapped youngsters, the Administration for Children, Youth and Families (ACYF) in 1976 established a national network of agencies known as the Resource Access Projects (RAPs). Presently 15 RAPs are in operation. The responsibilities of the RAPs are to:

—Identify local, regional, and national resources;
—Determine local Head Start needs and match them with available resources;
—Coordinate the delivery of services to Head Start programs;
—*Provide training and technical assistance;*
—Promote and facilitate collaborative efforts between Head Start and other agencies; and
—Provide resource materials to Head Start grantees.

The RAP network has been involved in many efforts related to training. As a part of their efforts during 1978-79, the network conducted workshops with Head Start agencies to introduce a series of manuals focusing on "Mainstreaming Preschoolers." The eight manuals, reflecting the eight handicapping conditions recognized by Project Head Start, serve as a program guide for local agencies. Also, with the RAP network, individual RAP projects conduct other kinds of training workshops for the Head Start agencies within their respective catchment areas, focusing on a variety of topics. Next year, the major thrust will be on recruitment, assessment, diagnosis, and developing Individual Educational Programs.

Head Start, the nation's largest preschool program, is involved in many training endeavors. As a provider of services for the handicapped, it too is concerned with personnel preparation in early childhood/special education.

Parent-Child Development Center

The final programming system to be discussed comprises the three research-oriented Parent-Child Development Centers. In 1968, the Office of Economic Opportunity funded 36 Parent-Child Centers for children under the age of 3, with their parents designated as the principal teachers. These programs influenced the later development of three research-related Parent-Child Development Centers (PCDCs): the Birmingham Parent-Child Development Center, the University of Houston Parent-Child Development Center, and the New Orleans Parent-Child Development Center. These research models were established to provide:

(1) educational programs for children under three;
(2) comprehensive health care for families; and
(3) activities to improve parent effectiveness, that is, *parent training strategies.*

The PCDC's were established to serve low-income families, and as such their programs were seen as intervention models for increasing the successful development of potentially high-risk or developmentally delayed infants. The success of these programs is evident in the research findings available. Program data are favorable. The parent-training component of each program is briefly described below.

The Birmingham Parent-Child Development Center

Designed to help low-income mothers, the Birmingham center has as its central focus a parent-training program with two major goals. First, mothers are expected to acquire techniques for increasing their ability to support their children's growth. Second, mothers are expected to improve their ability to cope with the demands placed on them by their children, placed on them as adults, and thus to improve their interactions with both their children and other adults.

A family enters the program when the child is three and one-half to five months old and remains until the child is three years old. All training of the mother and child takes place in the center, but parents are encouraged to continue implementing appropriate parenting behaviors at home. A carefully-sequenced environment provides for the development of strong, affectionate ties between mothers and their infants.

The Houston Parent-Child Development Center

The Houston center serves low-income, Mexican-American families. Each family participates for two years. The goals of the program are to develop and demonstrate ways of strengthening families, and to enable parents to optimize the intellectual, social, and physical development of their young children. Ultimately the program should enable the parents to perform more competently as educators of their own children, and enable the children to perform more competently in school.

The program is carried out in two phases: Phase one, the in-home program, begins when the child is one year old. Mother and child are visited weekly for one year by a trained bilingual (English/Spanish) teacher who attempts to help the mother become an effective teacher herself by involving her in interaction with her child. The sessions are parent-centered with emphasis on the mother as her child's primary teacher.

Phase two begins when the children are two years old. Professional teachers are given more responsibility for teaching the children, and the mothers attend group sessions focusing on home-management skills and child development.

The New Orleans Parent-Child Development Center

For parents in the New Orleans center, the goals are to increase the mother's parenting abilities and her sense of mastery over her environment. As in the Birmingham and Houston models, mother/infant pairs continue in the program until the children are three years old.

The center trains local community persons to serve as parent educators. Most activities of the project are center-based and revolve around three program components: child development, parent development, and support services. Program staff work with the mothers who, in turn, have major influence on their children.

Final reports from the three PCDCs for the first research phase, ending 1976, are being combined. By the end of this year a monograph will be available for additional information.

Summary

The purpose of this paper was to examine the current status of personnel preparation for early intervention programs. During that investigation, the training endeavors of four key program systems were explored: the National Diffusion Network, the Bureau of Education for the Handicapped, Project Head Start, and the Parent-Child Development Centers. Table 4 provides a listing of these programs along with information concerning thr target training audience(s) and program funding source.

Table 4

Summary of Training Endeavors Explored for Early Intervention Programs

Program System	*Training Audience*	*Funding Source*
National Diffusion Network	Local School Personnel	U.S. Office of Education
Bureau of Education for the Handicapped—		
—Division of Innovation and Development—Early Childhood Section	Any and all personnel providing services to preschool handicapped children	Title VI, Part C
—Division of Personnel Preparation	Professionals and Volunteers	Title VI, Part D
Project Head Start	Head Start Personnel	Administration for Children, Youth and Families
Parent-Child Development Centers	Parents	Administration for Children, Youth and Families

Investigation of the various program systems revealed that much training is occurring nationwide, and that each system has its own unique method of implementing training. For example, through the National Diffusion Network, training is provided to local education agencies by personnel from validated educational models. Within the programs funded by the Bureau of Education for the Handicapped, the training is very idiosyncratic. Programs vary from demonstration projects that are direct-service models to universities with master's-level training. A variety of target audiences are tapped including teachers, parents, and administrators. A third program, Project Head Start, focuses mainly on refining the competencies of Head Start program personnel. Finally, the fourth category of training explored was that provided by the Parent-Child Development Centers, in which parents serve as the focus of training efforts.

At present within the field of early childhood/special education, extensive training efforts are underway. Teachers, administrators, parents, ancillary personnel, early childhood service providers, and many others are receiving some type of training. The purpose of this paper was to examine some of those training endeavors. The scope of such a task is a tremendous one indeed.

Recommendations for Future Personnel Training Efforts

1. *Establish procedures for evaluating personnel training.* The great number of training efforts available suggests that steps should be taken to ensure that the training offered be of quality. One alternative to ensure quality is to develop a formative/summative evaluation mechanism. This would

allow not only for the continuous evaluation of personnel in training, as is true in virtually all training programs, but also for the overall evaluation of the training program itself, so that continuous modifications could be made as necessary. Going a step further, the summative mechanism would allow for the evaluation of an individual's performance in providing direct service following his/her involvement in a training program. A formative/summative evaluation procedure of this kind should become an integral part of the training process to evaluate more closely the kind of training being offered.

2. *Increase participation of direct-service staff and interns in developing training programs.* Often the very nature of a training program limits the applicability of the training content, because situations faced in the real world of providing services are different. For instance, although much training is offered in the area of parent involvement and education, many direct-service personnel are continually seeking "methods that work." Involving not only direct-service personnel but also parents in the planning and implementation of training models would make the training much more relevant; especially if cultural and ethnic differences are to be taken into consideration, persons representing these respective groups could be profitably involved at the planning stage.

3. *Increase the emphasis on skill and sensitivity for working with cultural/ethnic minority groups.* Significantly, there are too few programs concerned with providing training that will promote the skills and sensitivities necessary for working with children and families from different cultural and ethnic minority groups. Training programs should emphasize more the importance of incorporating ecological perspectives into their training efforts, to train personnel in programming more accurately and appropriately for the diversity of children and families being served. Specific training activities should range from non-biased child assessment instruments to effective parent programming. The concern for more ecologically based training is crucial, particularly in light of the fact that large percentages of minority children are being enrolled and served by a variety of preschool programs.

4. *Increase more coordinated personnel training efforts through the use of state funds and resources within/among states.* In any particular state it is not uncommon for direct service personnel to be unaware of the wide array of training opportunities available. This breakdown in communication often limits the opportunities that persons have to take advantage of training endeavors. Through a coordinated effort, perhaps under the umbrella of interagency coordination/cooperation, personnel at regional, state, and local levels could plan and coordinate efforts to maximize resources, manpower, expertise and opportunity. Some coordination is currently underway through state-level efforts, but much, much more is possible and necessary.

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Appendix A

University-Training Programs*

Early Childhood/Special Education

ALABAMA
Auburn University
Auburn, AL

ARIZONA
Arizona State University
Tempe, AZ

University of Arizona
Tucson, AZ

CALIFORNIA
California State University
Los Angeles, CA

COLORADO
University of Denver
Denver, CO

CONNECTICUT
Southern Connecticut State College
New Haven, CT

DISTRICT OF COLUMBIA
George Washington University
Washington, DC

FLORIDA
University of Miami
Miami, FL

University of South Florida
Tampa, FL

GEORGIA
University of Georgia
Athens, GA

Georgia State University
Atlanta, GA

ILLINOIS
Chicago State University
Chicago, IL

Illinois State University
Normal, IL

Northern Illinois University
DeKalb, IL

Southern Illinois University
Carbondale, IL

Southern Illinois University
Edwardsville, IL

University of Illinois
Urbana, IL

University of Illinois
Chicago Circle Campus
Chicago, IL

Western Illinois University
Macomb, IL

KANSAS
University of Kansas
Lawrence, KS

KENTUCKY
University of Kentucky
Lexington, KY

MASSACHUSETTS
Fitchburg State College
Fitchburg, MA

Northeastern University
Boston, MA

Elliott Pearson Child Development Institute 291
Medford, MA

Wheelock College
Boston, MA

MICHIGAN
Oakland University
Rochester, MI

High Scope
Ypsilanti, MI

MINNESOTA
Mankato State College
Mankato, MN

University of Minnesota
Minneapolis, MN

MISSISSIPPI
Mississippi State University
Startville, MS

NEW JERSEY
Jersey City State College
Jersey City, NJ

William Patterson State College
Wayne, NJ

Montclair State College
Upper Montclair, NJ

Rutgers University
New Brunswick, NJ

NEVADA
University of Nevada
Las Vegas, NV

NEW YORK
Columbia University
New York, NY

NORTH CAROLINA
University of North Carolina
Chapel Hill, NC

North Carolina Central University
Durham, NC

OHIO
University of Cincinnati
Cincinnati, OH

* List compiled at the Technical Assistance Development System, Frank Porter Graham Child Development Center, University of North Carolina, Chapel Hill, May 1978

OREGON
Oregon College of Education
Monmouth, OR

PENNSYLVANIA
Pennsylvania State University
University Park, PA

Temple University
Philadelphia, PA

University of Pittsburgh
Pittsburgh, PA

RHODE ISLAND
Rhode Island College
Providence, RI

SOUTH DAKOTA
University of South Dakota
Vermillion, SC

TENNESSEE
George Peabody College
Nashville, TN

Memphis State University
Memphis, TN

TEXAS
University of Texas
Austin, TX

VERMONT
University of Vermont
Burlington, VT

VIRGINIA
James Madison College
Harrisonburg, VA

University of Virginia
Charlottesville, VA

Virginia Commonwealth
University
Richmond, VA

Old Dominion College
Norfolk, VA

George Mason College
Fairfax, VA

WASHINGTON
Central Washington University
Ellensburg, WA

University of Washington
Seattle, WA

WISCONSIN
University of Wisconsin
Madison, WI

University of Wisconsin
Whitewater, WI

University of Wisconsin
Eau Claire, WI

Cardinal Stritch College
Milwaukee, WI

University of Wisconsin
Stevens Point, WI

University of Wisconsin-Stout
Menomonie, WI

WYOMING
University of Wyoming
Laramie, WY

Appendix B

Colleges and Universities that Provided Descriptions of their Teacher-Training Programs

Institution

1. University of Cincinnati
   Cincinnati, OH
2. Georgia State University
   Atlanta, GA
3. George Washington University
   Washington, D.C.
4. University of Illinois
   Champaign-Urbana, IL
5. Memphis State University
   Memphis, TN
6. University of Miami
   Miami, FL
7. University of Michigan
   Ann Arbor, MI
8. University of North Carolina
   Chapel Hill, NC
9. North Carolina Central University
   Durham, NC
10. Ohio University
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Report of the Task Force on Community Mobilization

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The Task Force on Community Mobilization took as its objective the following: to identify key issues in future planning for mobilization of communities toward optimizing the development of handicapped persons, both children and adults.

Definition of Terms. The term community was thought to have two meanings. In the general sense, it refers to all the people of a given geographic area who group themselves together in any way in the conduct of their lives. In a specific sense, community means any group of persons who come together around particular interests or participations, such as the professional community, the medical community, the political community, the community of the poor, etc. Mobilization as used here means to make ready for use, and carries a clear connotation of motion or movement.

Assumptions. The Task Force also made several basic assumptions about the locus of responsibility for the development of handicapped persons. First, parents are the persons *in charge* of their children's lives and, as such, final decisions concerning those children rest with them. PL 94-142 clearly makes this assumption. Second, society is *responsible* for all of its citizens in the setting of norms and standards and the establishment of public policy. The Gliedman (1979) paper of this conference makes this point, as have others (Caplan, 1969; Sascz, 1964). Third, the community is *accountable* for the implementation of this societal responsibility. A number of modern writers both professional and public have called for accountability at the community level (Reiff, 1971, Kennedy, 1979). Fourth, pluralistic models should be generated and implemented in all areas of work with handicapped persons, on the assumption that no one model for doing anything will work best for all persons or groups. Various models should be generated both for direct services to the handicapped and for community mobilization. Communities have individual differences which require alternative models in much the same way that persons do.

The Task Force identified four main clusters of issues pertinent to community mobilization. Each of these clusters also contains a number of sub-issues.

The WHO of Community Mobilization. The Task Force attempted to identify persons and groups throughout the community which should be mobilized for optimal benefit to handicapped persons, and toward which future planning should be aimed. In line with the assumption that all citizens should be involved in these responsibilities, an attempt was made to identify a broad range of persons and groups throughout the community. Some of these have been largely unused. Others have been either underused or used erratically and/or non-productively. This seems a good time to point out that the Task Force did not believe that all people should be involved in all the tasks relating to the handicapped all of the time. Such an expectation is neither possible, nor is it probably desirable. In line with the assumption that pluralistic models of community mobilization should be implemented, each community should decide for itself which model(s) it believes will be most productive for mobilizing its own people toward specific tasks. What is thought to be important, however, is that each of the persons and groups identified have some continuing responsibility for optimizing development of the handicapped, and that future planning be directed toward assisting each of them to assume that responsibility and carry it out.

1. *All citizens* should be mobilized in some way(s) at some time(s) toward optimizing the development of the handicapped. Specific tasks for which they should be mobilized are discussed in a later section, but include such things as public awareness and increased information, as well as assistance in services. This issue—the inclusion of all citizens in community mobilization—is perhaps one of the major differences between earlier kinds of planning and that which should now be undertaken for the future.

2. *Parents* of handicapped children have been shown to be one of the most effective forces in obtaining support and services for those children. What is probably needed here at the first level is simply continued support and encouragement for these efforts. In addition, for parents who have not been involved, there should be studies to see whether this has resulted from an absence of information, of motivation, of resources, of leadership, or other factors. Plans could then be drawn for more effective involvement of this group. Finally, parents and groups of parents who are already on line in the community or who can be brought on line should be systematically linked to other groups in a coherent, integrated fashion. This systematic linkage of a powerful parent force with other forces in the community is a key goal toward which future planning should be directed.

3. *Ecowaves** of persons surrounding the handicapped individual can also be mobilized toward optimizing his or her development. Such persons as siblings, other relatives, friends of the family, neighbors, etc. all have some vested interest in seeing that the handicapped individual performs as well as possible, and these can be mobilized toward assisting this in a variety of ways. Several of these are discussed in a later section.

4. *Handicapped adults,* including disabled veterans, have been one of the most under-used of all groups in promoting optimal development of other handicapped persons. They are frequently rich information banks and already plugged-in to resource networks. In addition, however, they can serve as role models of successful functioning. Systematic mobilization of this group has only become possible in recent times as more and more handicapped persons are reaching adulthood and assuming useful, productive roles. Future planning should take account of this emerging resource group.

5. *Physicans* are in an obvious first-line position to identify any handicapping or potentially handicapping condition. They might also serve in a variety of other linking roles to optimize development of the handicapped.

6. *Other professionals* such as educators, psychologists, social workers, lawyers, and a variety of others are beginning to rethink their roles in relation to the handicapped. Traditionally, these have provided a good base of service in some areas. But new approaches now need to be identified and implemented, such as assessment based more on a model of adaptive behavior than on the traditional deficit model, and a crossing of turf-lines in the establishment of interdisciplinary or transdisciplinary teams. Other issues for future planning would be the construction of a needs matrix for the handicapped, the identification of gaps or weak links in the service chain now provided by professionals, and the identification of service areas which need revision or rethinking.

7. *Churches* served as a bulwark in earlier America for people facing difficult times and situations, and it appears that they may be beginning to do so again. Future planning for community mobilization should target on this rich re-emerging resource.

8. *Service organizations* in the community have played a vital role in obtaining funds and services for handicapped children and adults. This history suggests that they are already mobilized in some communities and might be easily mobilized in others. Future planning for these groups might focus on the variety of ways they can participate in community action for the handicapped, including mobilization of other groups.

9. *Business, industry and labor* are other segments of the community which have been underutilized in optimizing the development of handicapped persons. The few examples of outstanding contributions by persons or groups in this segment need to be identified to serve as models for appropriate contributions by others. Future planning also might begin profitably involving these groups at once in assessing how their own considerable strengths and resources might contribute to helping the handicapped. Such a strategy would serve the useful purpose of beginning to get these groups more

* Ecowaves are the ever-widening circles of the natural environment surrounding the target person. For a child the first ecowave is the home and immediate family, the second the neighborhood and close friends and relatives, the third perhaps school, teachers, hospitals, doctors, etc.

involved, aware and moving toward common community goals, as well as of planning their own strategies, which has been shown to be related to more sustained participation and involvement.

10. *Schools* have traditionally been involved in delivering a variety of services to handicapped persons. They are also a group which has provided job training, career education, etc. to help handicapped young adults enter a productive adult life with more skills. The area in which they may have been under-utilized is community mobilization, through which they might share some of these awesome responsibilities.

11. *Persons over 65* are just becoming recognized for the rich resource pool they represent, usually including tremendous knowledge and wisdom, and frequently time and motivation to help. Such persons could play key roles in both community mobilization and in the delivery of some types of services. Examples are mentioned below. This newly identified resource group surely should be considered in future planning.

12. *Media persons* are another under-utilized group which can be of invaluable assistance to community mobilization, not just in terms of free advertising time they might provide, but also in their considerable expertise in community information processes. More effective means of involving this group should be an aspect of future planning for community mobilization.

The WHAT of Community Mobilization. The Task Force attempted to identify only a selective sampling of the types of activities for mobilization, inasmuch as the topic of specific programs for handicapped persons is being considered by another Task Force at the Conference (cf. Task Force on Programs). What the Task Force on Community Mobilization tried to do was sample from across service areas, particularly those outside direct-service delivery, in an attempt to delineate the range of services which communities need to address and for which they need to be mobilized. Examples include the following.

1. *Direct Services* was the area thought to overlap most with those of other Task Forces, and includes such things as educational and medical services. The Task Force on Community Mobilization had only two recommendations to future planners in this regard. These were an argument for pluralistic models to give communities opportunity to select those which best fit the needs of their particular handicapped population; and an argument for interdisciplinary teams, wherever possible, to increase the range of potential models and services provided, to decrease the potential overlap of services, and to extend the resource network.

2. *Identification* of handicapping conditions at the earliest possible time was felt to be a continuing need in many communities. The importance of early identification was high-lighted by the Anastasiow paper at this conference, and has been repeatedly stressed in the literature. Future planning for community mobilization needs emphasis in this area. Provision for early developmental screening would surely fall high on the priority list for community mobilization. Physican training for early identification of developmental disorders and, perhaps as important, for discussing these with parents, is another important early-identification task.

3. *Distal care* for both the handicapped person and the family, such as would occur when the child or adult needs to be hospitalized, schooled or otherwise served in an area outside his own community, is another important area for planning. Both the home community and the distal community need to be mobilized toward providing better services.

4. *Financial aid,* both directly to the parents of handicapped children, who, may have difficulty assuming the burden of costs during the all-important early years of the child's life, and indirectly as service to providers, is an area where community mobilization has been shown to be effective in the past. An important area for future planning is the identification and capture of all potentially available public monies, as well as mobilization of local communities toward providing whatever additional resources are needed.

5. *Ecowave care* for the successively larger number of persons surrounding the handicapped individual—siblings and parents, relatives, friends, neighbors, etc—is another area which has been left almost untouched and in which the community could play a major role. For example, the wealth of experience and wisdom of the "grandparent pool" could be extremely effective in such activities as providing extra attention for siblings at times when parents need to focus a disproportionate share of their attention on the handicapped child.

6. *Legal aid* is frequently available only to persons who can afford to pay or who live in larger towns and cities. Individual communities need to be mobilized to assist all citizens, especially those who are handicapped, in obtaining the full benefits of the law.

7. *Recreation* is only now being recognized as an important service area for handicapped persons in the same sense that it is for normal persons. Some service organizations have been very effective in this area in the past, and others or other segments of the community can be mobilized both to more fully identify needs in the area and to provide services.

8. *Respite care* and the provision of specialized baby-sitting training can, at times, become critical for the parents of a handicapped child. A number of persons and groups throughout the community can be mobilized to aid in this task.

The WHEN of Community Mobilization. The Task Force considered timing to be an important area in community mobilization. One reason why community mobilization efforts may fail is that timing is inappropriate, or mismatched with the goals and needs or with various community cycles. The Task Force considered the following timing factors.

1. Community mobilization is a *continuous* task. Community mobilization efforts often fall short because the excellent start-up activity lacks continued effort by the organizers, or because there is no effective transition, giving responsibility into new hands. Community mobilization is a specific task, just as are provision of direct and ancillary services, and prediction of success is tied directly to the degree to which individual communities treat it as a specific and continuing task. This is, in fact, perhaps the key problem in providing adequate and effective services to all handicapped persons across the range of needs, and the effectiveness with which other services are provided may be linked directly to the effectiveness of community mobilization efforts. In this regard, a first priority for future planning should be identifying and implementing strategies which will increase the continuity of community mobilization.

2. *Early provision* of services to the handicapped has been emphasized repeatedly in this conference. Community mobilization for providing these services therefore needs to begin even earlier, or a community runs the risk of not having services in place or accessible when they are critically needed.

3. Community mobilization is a *life-span* task. Services from the community are needed by citizens throughout their lives, and especially by the handicapped. This timing factor needs to be considered by future planners.

4. Some services are needed *periodically* and others at *specific times,* suggesting that community mobilization may need to be responsive to the rhythms of these needs. Again, the continuity of community mobilization is important, but while it should be continuous, realistic and effective community mobilization will vary according to needs and activities, and will display rhythms of its own. In fact, the failure by community mobilizers to take account of these cycles is one reason for the failure of community mobilization efforts. One example is the attempt to maintain the initially intense pitch of a total community fund-raising drive over a long period of time. Effective community mobilization efforts show appropriate life cycles, and one measure of their viability through time is the demonstration of these patterns. Planners need to be aware of these cycles, and take systematic account of them in thinking toward optimizing the development of all handicapped persons.

The HOW of Community Mobilization. The Task Force spent considerable time discussing alternative ways to get communities directly and continuously involved in caring for their handicapped. Again, in line with the assumption of pluralistic models, it was thought that individual communities would need to select various strategies to optimally match their own populations, patterns, etc.

Immediate Efforts. 1. *Community analysis* is an important first step for community mobilizers. A reality-based assessment of the people of the community, their beliefs, attitudes, resources and typical patterns of life is critical. To be effective in this regard community mobilizers must be able to step outside their own frameworks, and truly take the perspective of others. To the extent that they are able to do so, the prediction of success of their efforts will be increased. It is important to note here that actual data must be collected on these factors. To make assumptions about these factors without actually checking them almost invariably leads to error in at least some important ways, and constitutes a major reason for the failure of community mobilization efforts. A key issue for planners is to identify and specify strategies and models for community analysis.

2. *Public awareness* programs are an important first action step for community mobilizers once the community analysis has been thoroughly done. To get all the citizens of a community involved in caring for handicapped persons, one must first make them aware of the problems and needs. Individual citizens can then consider the alternative courses of action possible as they begin to think about and plan for their own involvement. While public awareness programs are a first important step in community mobilization, the need for maintaining these programs cannot be over-emphasized. Different individuals and segments of the community pick up on this information output at different times and in different ways. Again, one frequent mistake of naive community mobilizers is the assumption that once the word is out all citizens have (a) heard it and (b) begun to plan accordingly.

3. Establishing *networks* of various segments of the community is important in mobilizing toward optimizing development of the handicapped. Two types of networks were identified, those providing services and those providing information, although it was thought that there is some overlap between the two. Establishing networks of professionals who work with the handicapped is often a first step in increasing the efficiency and quality of services. Such efforts should be supported and can have valuable immediate effects in terms of such things as reduced duplication of services, more accurate referrals, less time lost by parents in agency shopping, increase in appropriate direct services, etc. A number of others can be hooked into the information networks, however, and of special importance here is including parents of handicapped children, and handicapped adults. Such persons have invaluable information and experience to aid others who are just beginning to experience a handicapping condition themselves or in their child, family member, friend, etc.

4. A potentially powerful tool for community mobilizers which only recently has become available is *behavior-setting technology.* Earlier work by Roger Barker (1965, 1968) and more recently by Allen Wicker (1979) have shown that these scenes-for-action (called behavior settings), which occur throughout communities, have specific and identifiable properties, and can produce different effects. Wicker has recently suggested that by varying how these settings are arranged, tremendous changes can be effected in the behaviors of all persons who enter those settings. A simple example would be increasing the number of people obtaining information about an important fund-raising activity by placing an announcement on a simple pedestal near the door of a public building rather than on an already crowded bulletin board. More complex examples would be the seating arrangement at a meeting, the order of the agenda for the meeting, or the relation of pre- or post-meeting activities to the objectives to be accomplished at the meeting itself. Some of these findings have been available from various areas of the behavioral sciences earlier, but behavior-setting technology provides a workable framework synthesizing a number of findings which before were either scattered or disparate. Systematic future planning needs to be done for the utilization of this powerful new tool.

5. The acquisition and deployment of *public and community monies* is another important *how* of community mobilization. Fund raisers in other arenas have for sometime utilized principles and techniques still untapped in work with the handicapped. Planners need to focus here specifically on behalf of the handicapped in the upcoming decade.

6. *Political action strategies* are another under-utilized technique for optimizing the development of handicapped persons. Handicapped parents have shown how effective a lobbying group can be if they are coordinated, integrated and sustained. Other political action techniques such as those used by Saul Alinsky (1971) can be brought to bear to mobilize other segments of the community.

7. *Continuity* in community mobilization has been mentioned before, but should surely be reiterated in this section on *hows*. A significant proportion of the success of any community mobilization effort depends on its continuity. One important factor here is planning for effective follow-up to be sure that mobilization activities are pursued as planned.

8. *Coordination* is another important issue in community mobilization. A frequent error on the part of community mobilizers is failure to coordinate their efforts with others already under way in the community. Again, community analysis, as a first step, should identify these other efforts, so that systematic coordination with them can be effected.

9. *Pluralistic models* also have been mentioned before but deserve further specification here. Communities will differ widely in practically all of their features. This suggests that no one model or set of models for mobilization will work with all of them. The important issue for planners is to identify a range and variety of models, which then could be matched with various community analysis data to permit each individual community to select the model most likely to work with its population, situation, etc.

10. *Encouraging the enforcement of laws* is another important feature of a community mobilization program. Legislative support for protecting the rights of the handicapped has increased in recent years, and the courts have been influential in effecting the participation of the handicapped in an increasingly widened sphere. Such efforts should be encouraged and supported by community mobilizers. Law enforcement agents can also prove valuable allies in the community mobilization process.

Long-Term Efforts. Three additional strategies were identified for community mobilizers which were thought to have more long-term effects. Because of their eventually major impact on provision of services for the handicapped, planners should consider these especially carefully.

1. Additional *physician training* with regard to handicapping conditions needs to be initiated. Many physicans do an excellent job of handling basic medical problems. What they may not do so well, however, is identify at an early stage the various developmental indicators of potential later problems. Inasmuch as the physican is often the first person who sees the child, he or she becomes a critical link in the identification and treatment-planning process. More developmental information needs to be designed and integrated into medical and pediatric curricula. A second area in which physicans may be seriously lacking is in providing information to the parents. At the first level, more systematic attention should be given the right of parents to be fully informed, and it is critically important that information about any potential developmental problem be provided quickly so that the crucial early periods of treatment are not lost. Physicans also need to be plugged-in to the information network concerning services for handicapped persons, inasmuch as they can serve as valuable links in the chain.

2. A second area vital in long-term community mobilization is providing systematic *training for potential parents*. By providing potential parents with more knowledge and skills for recognizing developmental markers in children, and for caring for those children optimally, a real preventive step may be taken. An example of a very effective program in this regard is the FEED Program (Facilitative Environments which Encourage Development) headed by N. Anastasiow at Indiana University. The methods of this and other programs need to be widely disseminated so that such training can begin as early as possible, certainly by junior high school level, as is already the case in many other countries.

3. The support, encouragement and participation in *research and evaluation of community mobilization activities* is an area of critical importance to future planning. Community mobilizers should be continually involved in the examination of their processes to determine which strategies work and under what conditions.

Summary. The Task Force on Community Mobilization took as its goal the identification of key factors toward which future planning should be aimed in the area of community mobilization for optimizing development of all handicapped persons. The Task Force made several basic assumptions, including, (1) that parents were in charge of the decisions concerning their children, (2) that society was responsible for the development of all its citizens, and (3) that individual communities were accountable for implementing this societal responsibility. Additionally, the Task Force assumed that the generation and implementation of a plurality of models for community mobilization was most likely to lead to greatest success across the greatest number of individual communities.

The Task Force identified a number of persons and groups which should be involved in community mobilization. At the first level all citizens should assume their share of society's responsibility for promoting the development of the handicapped. In addition, parents, ecowaves of persons surrounding the handicapped person (siblings, relatives, friends, neighbors, etc.), handicapped adults (including disabled veterans), physicans, other professionals, churches, service organizations, business, industry and labor, schools, persons over 65, and media persons all were identified as having some legitimate responsibility for community mobilization. Some of these persons and groups have been utilized effectively in the past. Others have been either under-utilized or used inappropriately or unproductively.

The Task Force addressed only selectively the question of what the community was being mobilized for, inasmuch as other Task Forces at the conference were addressing this question more specifically. The Task Force on Community Mobilization simply selected several activities illustrating the kind of efforts needed to optimize the development of handicapped persons, and gave particular attention to those outside the scope of direct-service delivery. In addition to direct-service delivery, the Task Force specified identification, distal care, financial aid, ecowave care, legal aid, recreation and respite care as important issues in community mobilization which need the attention of planners.

The Task Force also considered the timing of community mobilization, and agreed that community mobilization is a continuous task. Although the provision of services is a life-span task, communities need especially to be mobilized toward providing early services, in light of the research findings showing the importance of the early period upon later development. Periodic and other special needs may also require community attention. Of special importance to planners is the need to identify, generate and implement models of community mobilization which allow for the realistic life cycles of needs within communities.

The Task Force then turned to an in-depth consideration of the *hows* of community mobilization. This area appeared to require the heaviest emphasis in future planning. Key issues here were the identification of community-analysis techniques and strategies that would precede all other community-mobilization processes, public awareness strategies, establishing a series of networks in the community for both service and information, and use of the new behavior-setting technology, which is a management tool permitting more effective arrangement of groups in or components of the community. Other strategies also thought to be important include the use of political action to organize various components of the community, continuity of mobilization efforts, coordination of mobilization efforts, use of pluralistic models, and encouraging enforcement of laws relating to the handicapped. Long-term efforts included increased physican training for early identification of developmental problems, for informing parents, and for serving as a resource link in the information network. Training for potential parents and support of research and evaluation efforts were also identified as important for future planning.

In the final analysis it was agreed that the individual community was responsible for the welfare of the handicapped, and it is toward the community that mobilization efforts could best be directed. A number of modles and strategies can be applied from other disciplines, such as community psychology, sociology, and business management. Others will have to be generated. The first task is to establish a goal, such as *to have a community mobilization effort for the handicapped in progress in every community by 1985.* The task of future planners is then clear: to identify or generate a number of alternative models for community mobilization, and to plan for their systematic introduction into all communities. The task of the communities is equally clear: to identify and capture the resources, both human and fiscal, needed to implement community mobilization, and to start mobilizing!

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Report of the Task Force on Program Implementation

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Anastasiow's review of early intervention research findings and Gliedman's treatise on societal prejudice and discrimination toward handicapped persons provided the major focus for the Program Implementation Task Force. The Task Force began by looking for program implementation factors within the five successful program variables identified in Anastasiow's paper.

The role of specific intervention models

As Anastasiow points out, comparative studies of various curriculum models (e.g., cognitive, developmental, behavioral, perceptual-motor) have failed to demonstrate the superiority of one model over another. Curriculum models tend to increase intellectual functioning during the intervention period and reduce academic failure in later grades if the model includes "a planned and structured curriculum, high quality staff, a system of on-going supervision and planning, a low teacher-to-pupil ratio, and some form of parent involvement" (Anastasiow, 1979). It should be kept in mind that these results were obtained primarily from studies conducted with high-risk children (chronological ages three to eight) from impoverished environments, or with mildly retarded children. It is possible that the models may produce different effects when applied to younger as well as to more severely handicapped children, particularly if the evaluation criteria shift from intellectual growth (IQ changes) to social and emotional development, motor development, and self-help skill development.

In the absence of specific research evidence for moderately, severely, profoundly, and multiply handicapped children below the age of three, the Task Force attempted to identify the elements in Anastasiow's five successful program variables which might be effective for these younger, more handicapped children.

Structured curriculum

Little developmental growth is likely to occur as a function of incidental learning. It is therefore extremely important that parents, with the help of professional personnel, set specific behavioral objectives for each handicapped child as soon after birth as possible. Parents also need to be trained in task-analysis procedures so that they can systematically help their child attain the behavioral objectives established.

High-quality staff

To provide for the multiple needs of severely handicapped children, a broad range of multi-disciplinary staff must be prepared. These include special teachers, paraprofessional aides, physical and occupational therapists, speech and language clinicians, doctors, nurses, adaptive physical-education teachers, recreation workers, and social workers, to mention but a few. To keep up with the many rapid advances being made in the field, dynamic preservice and continuous inservice training must be provided.

Supervision and planning

Daily lesson plans for accomplishing short-term objectives must be developed. Each lesson should have an evaluation component to monitor the child's progress and to determine the next step needed by the child.

Low teacher-pupil ratio

Effective preschool programs for mildly handicapped and disadvantaged children tend to have one adult to four or five children. Severely and profoundly handicapped require even lower teacher-pupil ratios since such children are seldom capable of initiating or completing a task without supervision.

The task force suggests the use of the following paraprofessional personnel to lower the adult-child ratio:

1. Parent aides
2. Volunteers
3. Normal children peer tutors
4. College student trainees
5. Grandparents and foster grandparents
6. Teenage cadet teachers

Parent involvement

One of the major findings from Project Follow Through* was the importance of parent involvement. Although structured preschool programs for mildly retarded and/or disadvantaged children produced significant intellectual gains without parent involvement (Hodges, McCandless, and Spicker, 1971), those gains were maintained only when the program did include a strong parent-involvement component. Even more important, parent involvement appears to be one of the most crucial variables associated with "successful" school achievement following preschool and Follow Through interventions (Hodges and Sheehan, 1978). It seems to matter little whether the involvement takes the form of learning to teach one's own child, as in the Portage Project (Shearer and Shearer, 1972), observing others teach one's child, as in the High Scope Project (Weikart et al., 1978) or merely being trained to earn a better living, as in the Milwaukee Project (Heber et al., 1972). The crucial variable appears to be including parents as partners in planning an educational program for their children. For some parents such involvement may improve their child-rearing skills. For others, it may increase the sense of self-worth that comes from knowing that one is contributing to the cognitive, affective, and motor development of one's own child. For still others, being involved in educational decision-making for one's child may help reduce the hostility or feelings of powerlessness that many parents of handicapped and/or culturally different children feel toward public schools.

Parent involvement becomes even more crucial for those with more severely handicapped children. It is impossible to escape the many devastating stories which parents of such children tell about their frustrating experiences with nurses, doctors, social workers and other "so-called" handicapped-child experts. Doctors continue to either downplay the seriousness of the condition (e.g. he'll probably outgrow it) or overdramatize the hopelessness of it (e.g. he's a hopeless vegetable—your best recourse is to institutionalize him).

The Task Force highly recommends the following:

1. All hospitals should develop a plan for dealing with the birth of a handicapped child. The plan should include:

a) an appropriate procedure for informing parents that they have a handicapped child,
b) providing new parents with the opportunity of talking to experienced parents of children with similar problems,
c) information regarding how to care for their child,
d) community resources regarding services (diagnostic, educational, recreational, etc.).

*Project Follow Through is a variety of 1st through 3rd grade intervention programs which were designed to build upon the experience of disadvantaged children in Project Head Start.

2. All communities should have a centralized, continually updated resource file on community services to handicapped persons with a procedure for informing parents of the file's existence.

3. There should be a community-education program which teaches parents of handicapped children how to facilitate their child's development.

Future program implementation needs

The task force identified several areas of early-childhood education for which little information is presently available.

1. Most early childhood programs continue to stress cognitive, self-help, motor and language development. Although we recognize the importance of these skills we strongly urge that the affective domain not be forgotten. Like all children, handicapped children need to understand the emotions of joy, pain, empathy, sympathy, beauty, etc. In addition, they need to learn to deal with and, one hopes, change community attitudes toward handicapped persons. We encourage the development of an affective curriculum for handicapped children.

2. Anastasiow's transactional approach for breaking the negative interaction patterns among child, parent, and others deserves further study, particularly as a method of improving parent-child relationships.

3. If early-childhood programs for handicapped children are to be provided in states where preschool programs for non-handicapped children are not mandated, research evidence must be provided to show that such programs are essential to the optimal educational development of handicapped children. Such evidence is presently available for the language development of hearing-impaired children, the reduction of "blindisms" of visually handicapped children, and the prevention of mental retardation, learning disabilities, and behavioral disabilities of educationally deprived children. Similar positive evidence must be provided to justify infant and early-childhood intervention programs for children who are severely mentally retarded, emotionally disturbed, physically handicapped and/or speech and language impaired.

4. Advocates for year-long educational programs for handicapped children argue that gains made during the school year are lost without a summer program. If year-round programs for handicapped children should be provided at public expense it is necessary to provide hard evidence for that special need. In these days of tight monies, we as advocates for handicapped children would do well to depend less on public sympathy and more on gathering hard evidence to justify special expenditures for our handicapped children.

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Personnel Preparation Task Force Report

BY
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The initial issue that confronted the task force was to set parameters for the report. With regard to the preparation of persons who can facilitate the development of impaired children, the task force identified a number of important people in the child's environment: the parents, grandparents, siblings, teachers, bus drivers, psychologist, pediatrician, etc. But a superficial treatment of the training needs of all these people was not considered a productive use of discussion time. Since, in the important areas of teacher and parent training, Elouise Jackson's paper offered a comprehensive analysis of both current efforts and future needs, the task force decided to focus its attention on the training/educational needs of two other groups who also play critical roles in the developmental facilitation process, but for whom systematic training and national attention are lacking: the physician and the adolescent.

This report considers these two populations with specific references to training considerations and to the knowledge and skills which it is desirable that they possess.

The Pediatrician or General Practitioner

The pediatrician and primary care physician perform two functions critical to the well-being of a child and his family. On the one hand, this person locates and coordinates the services of medical, therapeutic, and educational specialists if the child needs these. On the other hand, he or she becomes the contact person for parents and others who have questions about the child. The physician's ability to secure appropriate services will depend highly on his/her belief in the worthiness of such services, his knowledge about their nature and purpose, and most of all his recognition that the need for such services exists. His or her ability to provide meaningful responses requires broad knowledge about such areas as: child development, early intervention strategies to enhance development, handicapping conditions, etc. The physician is also expected to use communication strategies that enhance parent-physician relationships, as well as relationships with non-medical professionals. But training in these areas may not have been included in the medical school curriculum, and the plight of the family who receives inappropriate guidance, inadequate information, or insensitive attention is all too familiar.

Training Considerations. The effectiveness of physician training in child development and its related areas will depend highly on the techniques used as well as on timing. The training process has been greatly facilitated by work done to date by special task forces within their national associations (i.e. American Academy of Pediatrics) who have not only identified child development as a top priority within training programs, but who also have taken the philosophical position that the *person,* not the *person's illness,* should become the focal point of training.

In terms of the medical school curriculum, determining the critical time for introducing certain content and skill development material will require careful analysis. For students struggling with the unfamiliarity and fatigue commonly associated with the first and second year of pediatric residency, it may be necessary to delay child development content until the third year.

The training of the practicing physician is a different matter. Here, the issue is one of generating interest and/or willingness on the part of those who are to be "trained," or in reality, "retrained." The needed leverage now comes in the requirement by the American Medical Association (AMA) that physicians must have additional units of in-service education on a continuing basis. Efforts are being mounted through the medical University Affiliated Facilities to design units/lessons on screening, handicapping conditions, communicating with parents, etc.

The American Academy of Pediatrics has recently received funds from the Bureau of Education for the Handicapped to develop a model curriculum and conduct in-service training programs for pediatricians and primary care physicians serving handicapped children. The goal of the project is for physicians

to recognize that their participation in the individualized educational planning process is important, and to take initiative in opening constructive communication with professionals serving handicapped children and their parents.[1]

The Nisonger Center for Mental Retardation and Developmental Disabilities also recently received funds from the Bureau of Education for the Handicapped to develop a curriculum for pediatric residents in handicapping conditions. The overall goal of this project is to develop a curriculum at the national level focusing on handicapped preschool children and their families for pediatricians during their three year residency training program.[2]

These efforts must be encouraged and expanded. The development of these kinds of cross-disciplinary interactions will enable professionals in special education and in medicine to utilize one another's services most effectively in planning the total range of intervention strategies.

Disseminating these training materials will require thoughtful planning, particularly where professionals living in rural areas are concerned. In the larger communities, one typically finds some facility for higher education—a university, college, or junior college—and within that environment someone is concerned about personnel preparation in the local area, and can respond to requests for training by serving as a link to people who have the knowledge and can provide the training. In smaller communities, these resource persons may not exist. Those who desire training may not know who to call at the local level, and may not have the time nor the energy to explore training opportunities outside their home community. Geographic isolation may also bring complacency in professionals who do not recognize that the services they provide are inappropriate. The physician who says that "the kid is going to grow out of it" must learn that that advice is wrong.

Efforts to meet the needs of rural physicians and other professionals are increasing in the more urban diagnostic centers. Field-based teams of professionals are beginning to go into smaller communities and providing on-site training and technical assistance. These kinds of outreach efforts must be expanded and reinforced.

Other less formal strategies for training exist and can aid dissemination efforts. And although the physician is the main target, these techniques can apply across disciplines.

First the publications of the professional associations are a useful vehicle for dissemination. Not only could special issues be created, but reading designated articles could count toward completion of the AMA required in-service units.

The telecommunication systems have enormous potential for training. For example, programs can be designed to be broadcast over special radio channels for particular groups who need have only a special receiver in their home or office to hear it. These systems are already in place for physicians in certain geographical areas; now the question becomes one of designing the "message" and convincing the "system" of its importance and timeliness.

Public awareness campaigns are emerging all over the country and are fighting for recognition for the impaired person. The success of these efforts is reflected in all the forms of mass media and in the motion picture industry, but the emphasis to date has been primarily on the adult population with some attention to school-age youth. Now pressure must be brought to bear on these groups to focus on the very young child and on the critical issues of early detection and early programming. And when the media does respond, it is imperative that professionals and parents respond too—for example via the editorial page—with appreciation and encouragement.

1 For more information contact American Academy of Pediatrics, P.O. Box 1034, 1801 Hinman Avenue, Evanston, Illinois 60204

2 For more information contact Dr. Michael J. Guralnick, Nisonger Center, The Ohio State University, 1580 Cannon Drive, Columbus, Ohio 43210.

Parents represent one of the best resources in the training of physicians and other professionals. They have organized and have become outspoken in the courts and in numerous publications (see for instance the very poignant collection of stories which Turnbull and Turnbull have edited in *Parents Speak Out: Views from the Other Side of the Two-Way Mirror).* Their voices are now being heard and their demands responded to in legislation and in publications designed expressly for them (e.g., *The Exceptional Parent Magazine).*

In particular, the parents of young impaired children who participate in model HCEEP programs (see Anastasiow's paper) have received extensive training in a variety of areas including child advocacy. Program staff hear repeated stories of parent conversations with physicians in which the parents of very young impaired children are able to provide information about the nature of the impairment and the availability of other services, and also express their interest in serving as support persons for other families with similar problems.

Knowledge and Skills. Because of the time limitations of the conference and the potential breadth of this topic, members of the task force were asked to identify the most important area in which physicians should be knowledgeable and skillful. All identified the same area: "communicating with parents." The task force was fortunate to have as one of its members a knowledgeable and articulate parent who provided many illustrative examples of ineffective and effective communication in doctors' offices.

In essence the issue is to train the physician to be sensitive to his or her own suggestions about the ideal way for the parent to behave with the child. What is "good" parenting when the child is impaired? Does the impairment dictate the kinds of behaviors to expect from parents? Is there only one way that the Down baby is going to learn? There is a danger in the way professionals get together to talk about patterns of behavior desirable for parents with an impaired child. Too often these suggestions are presented as *the only* way. Such a position has four basic flaws: 1) it assumes that the specifics about child rearing are all known, which is not true; 2) it assumes that the child's impairment alone should dictate what is appropriate behavior for the child's age (while, for example, it may be appropriate behavior for a child, regardless of impairment, to be stubborn at the age of four); 3) it assumes that parents can be consistent and not be confused by their own upbringing or unaffected by their own emotions; and 4) the presentation of one approach may imply a conditional cure, and this may cause the parents anxiety if that approach is not followed explicitly.

The emphasis on impairment and prognosis is misplaced. The impaired child must be viewed first as a child, and then as a child with special needs. Professionals and parents need to sit down together to share ideas and strategies and to plan for the child's future. It is not acceptable for the professional to tell the parent what to do. The child is the parents' child; the child is part of the parents' life.

The Non-Impaired Adolescent

Seventh and eighth graders are at an ideal stage in their own development to receive new experiences, ideas, and issues. It is a time when attitudes start to set, when emotional energies can be channeled into experiences that will enhance the self concept, when young people can begin to understand and appreciate differences in people, and to learn about impairments in development.

But these same youngsters are now physiologically mature earlier than ever before, and are conceiving at an earlier age. The number of teen-age pregnancies has increased rapidly, and to alarming proportions, especially among 10-14 year olds. The rate of low birth-weight premature infants born to young mothers is high, and many of the infants who survive suffer perinatal stress.

Given the above and considering that research has shown that perinatal stress conditions can be overcome by facilitative child-rearing practices (Werner et al, 1971), it behooves the public schools to

require a course on child development. Ideally this exposure should occur at the middle/junior high school level, before these young mothers have babies and drop out of school, and in time for young people to realize that every child, whether mentally or physically impaired, socially or economically deprived, is a person with feelings and needs.

Training Considerations. The course of study would focus on the care and development of both normal and impaired children. The learning experiences would be a combination of classroom instruction and practicum in health care facilities and child development centers.

An exemplary program in this area is FEED (Facilitative Environments Encouraging Development). Funded by the Bureau of Education for the Handicapped, Handicapped Children's Early Education Program, FEED is based on the following goals:

a. To help young people develop positive attitudes toward normal and handicapped children
b. To make young people aware of the responsibility of child care—as caregivers, teachers, or parents—and to foster a respect for these responsibilities
c. To help young people learn about normal and abnormal child development
d. To enable young people to care effectively for normal and handicapped infants and children and to remedy some handicapping conditions
e. To prepare young people to be informed consumers of child care and health services
f. To make young people aware of career opportunities in the fields of child care and health services
g. To encourage young people to perceive themselves positively by providing them with useful skills and a chance to use these skills in successfully caring for children in work-oriented settings
h. To help young people, by teaching them the processes of human development, to understand themselves and to be better able to constructively influence their own lives.[1]

The setting for practicum experience must be selected with care, since that experience will be extremely influential. The most promising setting for a young adolescent:

a. is receptive to his participation
b. is governed by order and structure and has evidence of a planned program (as contrasted with a babysitting arran, ıment)
c. demonstrates positive child-rearing practices (i.e. the absence of punitive measures to achieve behavior control)
d. is responsive to youngsters, adolescents and younger children.

The kinds of examples observed in such settings, however, provide only the framework for learning. The problems that the adolescent sees in the practicum are brought back to the middle school or junior high classroom for discussion. There the knowledge and/or theories about child development can be shared. This combination of training and theory can enhance the youngsters' problem-solving skills to help him/her meet new situations.

In the process, these youngsters will share their experiences with siblings and relatives. The strong and solid communication links among adolescents are impressive; we need only provide the appropriate information and/or quality experience to a few, and the rest will know about it, quickly. But caution must be exercised, for inappropriate information can spread through the same channels with equal speed.

As youngsters have the opportunity to see the consequences of pregnancy in young people, they will recognize the varieties of responsibility in child care. Then, by expressing their own opinions and attitudes, and with the assistance of an adult to facilitate their thinking and provide additional information, they can begin to examine their attitudes, a responsibility that finally belongs to the student alone.

[1]For more information about FEED, contact: Institute for Child Study, 10th Street and By-Pass 46, Bloomington, IN 47401

A well-designed course of study coupled with appropriate practicum opportunities could have very positive long-term effects. Introducing these seventh and eighth graders to imapired youngsters as well as to the non-impaired would enable them to compare similarities and differences in physical, social, and emotional development, but also to see that all children have basic needs for affection and care. Ultimately the increased knowledge and skills acquired by these adolescents will enhance their own parenting behavior. The model demonstration programs established by the Early Childhood Assistance Act are ideal settings for these youngsters and for meeting the training needs of various persons in the area of early intervention. These programs exist in every state, and provide an excellent opportunity for observing direct service delivery, and for conversing with staff and parents about children's needs, about the nature of certain impairments, and for certain groups, about the planning and implementation of a program.

Another setting that holds great promise for practicum experience is the hospital. Increasing numbers of these have on their wards impaired children who formerly were in institutions, state homes, and orphanages.

Other settings that can be utilized for training include the University Affiliated Facilities (UAF's), nursing homes, and an increasing number of preschool programs that are attempting to incorporate impaired children into their settings.

A quality setting probably will accommodate no more than one or two students at a time. Too many demands on the staff of an excellent setting could be disruptive. If the availability of appropriate settings is limited, it would be more desirable to train fewer students in those that are dynamic and responsive than to chance placement where the student would observe poor child-rearing practices.

The potential impact of such a training effort is best reflected in a statement by Nicholas Anastasiow, Director of the Institute for Child Study (the center for the activities of FEED), who shared the following with the task force, "Anecdote after anecdote from our students who work with handicapped children at the center portray marked changes in attitudes towards handicapped children. The students became very critical of their peers who became parents at a very early age and had premies and low birth weight babies. . . "

Knowledge and Skil s. A course in child development with opportunities for concurrent interactions with very young children provides many possibilities for learning, but these will also depend on the nature of the population with whom the adolescent interacts.

Ideally, the instructional areas will include:

1. patterns of physical, social, emotional, cognitive, and language development in children ages 0-5
2. major handicapping conditions of young children who are physically handicapped, cerebral palsied, mentally handicapped, etc.
3. child-care approaches
4. vocational opportunities
5. community resources and services
6. integration of children with differences
7. family living
8. human dignity and personal values
9. stigma/deviance/differentness
10. handicap as a social response

SUMMARY

During the last ten years, the expansion of knowledge about human learning has been revolutionary. This new information needs to be disseminated across a number of domains: to teachers, pediatricians, parents, and adolescents. But personnel preparation must have another training goal: people must be able to organize, to influence, to motivate. Adults need to be able to go into communities and convince school personnel that teaching child development to seventh and eighth graders is essential, so that legislators will allocate funds for educational programs about very young impaired children, so that communities will establish and maintain services and programs for impaired children and their families, and so that pediatricians will refer children to educational, mental health, and other social service agencies, even if a problem is not definitely diagnosed but suspected. These are all sensitive issues and typically not part of our public school, college, or professional school curriculum. Hopefully the planning for the future training of physicians and adolescents will incorporate the implications of this report.

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Report of the Task Force
On Evaluation and Dissemination

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The Task Force report on evaluation and dissemination was concerned with how the delivery of services to impaired children might be evaluated, and how information about available services may be disseminated.

Not being able to address particular program models, the Task Force on evaluation and dissemination had to think at a general level. This report deals with perspectives and guidelines rather than with specific strategies, designs, or techniques.

The two areas the Task Force was asked to consider, evaluation and dissemination, are rather different from one another. There is little confusion about how evaluation might be conducted; local projects will almost always have evaluation services available as part of their local staffing, or at the least can contract to hire evaluation services to carry out whatever tasks seem appropriate. Dissemination, on the other hand, has no such clear agents or agencies. Hence the perspectives and guidelines with respect to dissemination are, as will be seen, even more general and tentative.

Evaluation

1. *There are many ways to evaluate, and there is no basis for claiming one right way.* Traditionally, of course, evaluation has been based upon a specification of objectives and a determination of whether those objectives have been achieved. But evaluation has also been defined in other ways:

1) as an activity to service *decision-making* (in which case one asks not about objectives but about who are the decision-makers, what decisions they will make, when, by what criteria, etc., to determine what evaluation information to collect);
2) as an activity to determine *effects* (in which case one asks what happened regardless of whether the effects are intended or unintended, main effects or side effects, etc.);
3) as an activity that makes *qualitative judgments* in terms of well-understood even if not always articulated internal criteria (as in the case of peer reviews of funding proposals, or critical assessments of what goes on in classrooms utilizing expert judgment as described by Eisner's (1979) proposals for educational connoisseurship);
4) and as an activity that attempts to be *responsive* to the concerns and issues of relevant audiences such as teachers, parents, students, funders, and so on (in which case one starts by discovering what those concerns and issues are and then collects information that sheds light on them). Methodologically, evaluation has included, at the extremes, the experimentally oriented pre-post design heavily dependent on test scores and elaborate quantitative/statistical analyses, and the naturalistically oriented field study relying heavily on qualitative techniques such as interviews and observations. While there is a good deal of debate about the relative merits of these approaches, no one approach has emerged as clearly superior. Each has advantages and disadvantages, and the decision about which one to use must be made in terms of trade-offs for the particular evaluation situation in which one finds oneself.

2. *The situation under discussion here, i.e., delivery services for the developmental facilitation of impaired youngsters, seems to favor the use of a responsive model with major dependence upon qualitative,* naturalistic* approaches.* There are a number of arguments in favor of this assertion. First, we are speaking primarily of community services which are likely to be quite different in different communities, for a variety of fiscal, cultural, and political reasons. Evaluation designs will have to be tailored very much to that local situation and, as such, issues of generalizability are moot. Indeed, the

*Naturalistic approaches are based on a phenomenological (field-oriented) inquiry paradigm and rely heavily on qualitative methods, e.g., field observation, interviews, documentary analysis, ununobtrusive measures.

evaluation strategy should involve assessment of just what local conditions are so that an appropriate evaluation design responding to local needs can in fact be developed. Such an assessment suggests a field study, using naturalistic methods in a discovery posture (rather than an experimental approach in a verification posture). Second, emergent theory about the appropriate kinds of programs needed for developmental facilitation (see the Anastasiow paper) suggest that they need to be *transactional,* i.e., taking account of an inter-action between an impaired youngster and his/her caretaker (as one instance) that continuously produces a *new context* for the youngster while at the same time altering the youngster as well. Thus, as time progresses, both youngster and context are in a continuous flux. Assessment of such changes requires an evaluation model that is more ecologically (i.e., environmentally) oriented than has traditionally been the case. Third, if impacts of facilitation programs are to be meaningfully assessed, account must be taken not only of their impact on the impaired child but on all the significant others relating to him—teachers, parents, siblings, "normal youngsters," and so on. Again, an evaluation model oriented to a variety of audiences and their concerns seems most appropriate. Fourth, it should be noted that the impact of a program can most meaningfully be evaluated in terms of its impact on the individual child—to know that a program is effective with sixty percent of the children eighty percent of the time is not terribly meaningful to the parent, teacher, social worker, occupational therapist, or whoever happens to be working with Johnny Jones, an impaired child. Evaluation models that can focus on individual interactions must surely be preferred. Finally, it may be noted that the conventional models, despite their widespread usage, have not proved especially useful in evaluating programs in the past. Surely it is time to try some alternatives.

3. *The value of any program proposed for application in a particular context needs to be determined in that context.* The root of the term "evaluate" is value; thus the purpose of evaluation is to determine the value of some entity. But value has at least two aspects, which here will be labeled "merit" and "worth." Merit is a quality *intrinsic* to an entity—quality characteristics that accompany the entity wherever it may be found. Thus a proposed program might be based upon the best research, embody the most up-to-date perspectives such as transactionalism, and be internally consistent and logical. Determinations of merit would thus be made once and for all, and, while no doubt experts might disagree on just what criteria to bring to bear or to what extent a particular program met the chosen criteria, decisions could be made which could be stamped on the program itself, just as "sterling" can be stamped on silver, to indicate *intrinsic value.*

Worth, on the other hand, is a quality dependent not only on the program itself but upon the *interaction of the program with a context.* It cannot be determined once and for all, but must be assessed situationally. Whether a given early intervention program has worth depends on such factors as the number and types of impairment found, the fiscal resources of the community, the motivational level of parents, the previous training and experience of the professional personnel who will run it, and so on. Most particularly, the utility of a program with a particular child depends on the interaction of that child with the program; high merit alone will not automatically guarantee high worth.

From this analysis we may conclude that merit, determined elsewhere, cannot be a sufficient ground for utilizing a program locally. One would not wish to use a non-meritorious program, of course, but given one that is known to be meritorious, other local evaluations need to be done to determine its worth. Such local evaluations may well lead to adaptations being made to provide a better "fit" between the program and the context; in that sense local evaluations may be thought of as formative. However, when the best fit possible has been attained, local summative evaluations still need to be done. Again, we may notice that either formative or summative evaluations of worth must take into account local context, for which ecologically oriented, qualitative evaluations are likely to be the method of choice.

4. *Evaluation is frequently confused with documentation, on the one hand, and research, on the other; both confusions are detrimental to conducting good evaluations.* The first confusion arises because of a failure to recognize that the complete act of evaluation includes not only description but also *judgment.* Documentation is of course essential, but knowing how many dollars were spent, how many programs were mounted, how many children were served, how many other agencies cooperated, how many types of professionals and para-professionals contributed, what the average length of service time was for a youngster, and the like is not sufficient for judging the worth of a program. Judgmental data are essential.

The second confusion arises because of lack of clarity about the different *purposes* of evaluation and research. Evaluation is intended to determine the merit or worth of some entity, while research is intended to provide new knowledge that will have meaning in a variety of settings. This confusion is confounded, of course, by the fact that researchers and evaluators, whether traditional or emergent in their epistemologies, tend to use the same tools. But that fact makes them no more alike than are, say, carpentry and plumbing simply because the practitioners of these two arts both happen to use saws and hammers. Evaluations should not be subordinated to research interests, and it is probably inappropriate to seek research generalizations from local evaluations, remembering that such evaluations *must* focus heavily on local context and thus are, virtually by design, antithetical to generalizations.

5. *Responsive, naturalistic, ecologically-oriented evaluations tend to lean heavily upon the evaluator himself as a major instrument; hence it is incumbent upon the evaluator to make every effort to preclude his own biases from influencing the evaluation outcomes.* Conventional evaluation approaches have, it is frequently and appropriately asserted, tended to overemphasize *rigor* at the expense of *relevance,* and so it is not surprising that the emergent responsive, naturalistic approaches, perhaps in over-reaction, tend to overemphasize in the opposite way. But it must be realized that there is no reason why both approaches cannot profit from attending to both questions. Now it is well known that these two qualities stand in a trade-off relation to one another—the more one is emphasized the less can be the other. Over-imposition of strict control to assure internal validity can, for example, severely damage external validity—often the results of one laboratory experiment can be generalized only to another laboratory. Similarly, overemphasis on relevance can result in findings that are meaningless because the inquiry was essentially undisciplined.

The problem becomes especially acute in naturalistic, responsive evaluations because many times the evaluator is *himself* the instrument, e.g., in interview or observational situations. His concern for relevance may cause him to overlook assessing himself from the point of view of instrumental rigor, and under such circumstances, his own attitudes, perspectives, beliefs, and concerns may shape the outcome of the inquiry more than they ought. Special care to prevent this contingency is called for.

6. *Traditional evaluations have tended to focus too immediately on the outcomes of a program (which is frequently conceptualized as a "treatment") and have overlooked other equally important aspects.* Among these other aspects to which the evaluator should attend are at least these:[1]

a. Programs have impact on many relevant others—e.g., parents, siblings, teachers, "normal" youngsters interacting with the impaired youngster(s) (e.g., in a classroom), and so on. All these impacts should be assessed in determining the worth of a program.

b. The child cannot be approached simply as the object of a particular treatment. He/she exists in a complicated environment, including not only the particular impairment but a variety of physical, social, and cultural factors. A program cannot be understood except in such a context.

c. Programs themselves cannot be taken to be constant. Conceptions of what the program is about mature and develop. Staff gain experience. Fiscal exigencies may cause the program to have discontinuities. Staff turnover rate may be determinative of the effectiveness and consistency with which

[1] The order in which these aspects are listed is of no importance.

the program is applied. And so on. Continuous monitoring of such factors, accompanied by efforts to discover what changes in them mean to the program as a whole, is essential.

d. The extent of agreement or conflict in a program staff about the basic philosophy guiding the program is heavily determinative of outcomes. A heterogenous staff (e.g., a staff consisting in part of behaviorists and in part of humanists) is likely to become quickly immobilized. On the other hand, a homogeneous staff, while finding it easy to make decisions and agree on operations, can quickly become parochial. In the former case the evaluator can reflect to the staff the consequences of their disagreements (while not taking responsibility for their resolution), and in the latter case he can arrange for the critical inputs needed to keep the staff moving ahead.

e. Programs likely to be effective in providing for the developmental facilitation of impaired youngsters are complex and require inputs from a variety of professionals. These professionals, moreover, are likely to be located in different agencies—hospitals, clinics, social work agencies, schools, etc. Cooperation is essential. A major task for the evaluator is to continually assess the degree and nature of such cooperation in order to maximize it.

f. Program staffs frequently lack persons who have training in working with adults. Yet programs cannot focus only on the child, but must relate to his/her parents, teachers, doctors, and so on. Evaluators should include this variable in their assessment of staff adequacy.

g. It is commonly understood that parents must retain the primary managerial and decision-making power for their own children, except under limiting conditions (e.g., child-beating, extreme youth, emotional instability). Evaluators should assess this characteristic of programs among others.

h. Parent involvement is crucial, not only in terms of making decisions on behalf of the impaired child and carrying out certain aspects of the program, but also in the governance of the program itself, e.g., via a policy board. Evaluators should attend to this variable in assessing programs.

i. Traditional evaluations have not focused sufficiently on long-term, developmental aspects of programs. This can probably be traced to funding patterns, which tend to be short-term, even renewable year to year. These patterns are effective disincentives to planning and carrying out long-range studies. Nevertheless, evaluators should not neglect this dimension and should press for the resources necessary to plan and implement such studies.

j. Finally, evaluators should not shrink from evaluating aspects that cannot easily be measured or which appear, on their face, to be "subjective." For example, such overall assessments as to whether youngsters exposed to a program are simply happy are rarely attempted. Such outcomes are said to be "intangible," and because they probably could be assessed only by judgment are dismissed as unscientific. But of course we rely on judgments in many areas (think for example of certain Olympic athletic contests or literary criticism), and there is no reason to believe that information gathered by such means cannot be useful. In this case somewhat less than traditional emphasis on rigor and somewhat more on relevance would be a useful compromise.

Dissemination

As noted in the *Introduction,* the picture with respect to dissemination is not so clear, nor so easily generalized about, as is that for evaluation. Nevertheless, some comments can be made:

1. *Like evaluation, dissemination can be defined in different ways, and the definition adopted has enormous consequences for subsequent actions and decisions.* There cannot be dissemination without something to be disseminated: an innovation, an idea, factual information, etc. In dealing with delivery systems for developmental facilitation, it is likely that what dissemination will involve are alternative delivery systems and alternative facilitation programs. Suppose that a delivery system option and a program option have been identified. What would it mean to say that these options had been effectively disseminated to a local community? Would one require that the system or program be replicated exactly

as developed elsewhere? Would one allow certain adaptations to be made? Would one allow a complete deviation from the original form, on the assumption that it was sufficient that consideration of the option led the local community staff to study its own problems and then to devise means for dealing with them, even though the original option(s) might have been abandoned in the process?[2] From the earlier discussion about merit and worth in an entity to be evaluated, this task force concludes that an adaptation posture probably would be most appropriate, but whatever conclusion one might come to, it is apparent that whether one regards the object of dissemination to be replication, adaptation, or consideration poses very different tasks for the disseminator.

2. *Whatever decision one might make about the meaning of dissemination, it is apparent that there is no complete system for dissemination currently in place.* The National Diffusion Network does include some relevant programs, but limited to those that have been developed under Federal subsidy, have evaluation data approved by the NIE/OE Joint Dissemination Review Panel, have persons who have been willing to write proposals to be funded as Developer/Disseminators, and that have been accessed through some intermediate agency, most likely the system of State Facilitators. Resource Access Projects (RAPs) serve as linking agencies for Head Start programs. Some states have exemplary networks, such as the SERCs (Special Education Regional Centers) in Ohio, but do not tie directly to a national network and typically have a special audience (schools in the case of SERCs). Most but not all states have early childhood specialists or consultants who typically do perform some linking functions, but the task is too large for this group given their resources. Thus, there are bits and pieces, but no coordinated national system.

3. *It is unlikely that the existing bits and pieces can be welded into a coordinated national system.* Each of the existing bits has its own funding source, its own purpose, its own enabling legislation, its own constituencies, and its own political base. These facts mean not only that it would be difficult to bring the pieces into conjunction, but also that the bits and pieces cannot be counted on to see the development of a national system as a uniform good. Indeed, one might argue that should anyone have pretensions of *developing* a national system, it would be better strategy to form some sort of coalition of the existing bits, making it possible for each to maximize its contribution, than to expect each to subordinate its interests to a national system and, uncomplainingly, become a part of it.

4. *Whatever may be the resolution of the problem of an adequate dissemination network, there are three aspects of the dissemination problem that need immediate attention:*

a. The most urgent aspect is that of a means for determining, in any local context, what parameters of a delivery system and of a program would best meet local needs. It is likely that the role of evaluation and of dissemination come into conjunction here. What is needed is a *needs assessment,* as evaluators are wont to use that term, in every local situation, to specify what the parameters of an adequate delivery system and program might be. Such a needs assessment would provide a base both for seeking out possible responses to the local needs, and for assessing whether those responses, once in place, in fact eliminated or ameliorated the needs.

b. A second aspect has to do with awareness. Assume a local need has been identified, and that there exists, somewhat, an idea, a program innovation, an administrative pattern, etc., that responds to it exactly. That response will have absolutely no utility for that local situation unless the locals are *aware* of its existence. Indeed, awareness is the basis for any system of innovation. There is little point to thinking about elaborate national systems (or better, in view of *3* above, of elaborate national coalitions) for the delivery and institutionalization of innovations, when the large majority of local communities lack the means for awareness about available assistance. Most communities simply do not know about even the

[2] These three perspectives are frequently called by the terms *replication, adaptation,* and *springboard.* A study of the National Diffusion Network by the staff of The Network (Amherst, MA) is currently under way which will examine these three postures as they might be taken by the Developer/Demonstrators and State Facilitators that characterize the NDN.

simplest of new ideas, programs, or delivery systems. Much concentration on this aspect of dissemination is needed now.

c. A third aspect has to do with relevant audiences. Those disseminating agencies now in existence, whether Federally supported national networks such as NDN or RAP, or private concerns such as publishers with limited materials to sell, tend to contact the wrong audiences. If school persons are to be contacted, letters are often addressed to a superintendent or principal. If hospital personnel are involved letters go to hospital administrators. Agency personnel are typically contacted via an agency director or head. And so on. All too often those who receive these communications do not understand their import, do not know to whom to refer them, and/or lack adequate mechanisms to move them from their own desks to the desks of more relevant individuals. A massive effort should be made to devise a directory of persons involved with these developmentally facilitative efforts, suitably indexed, so that relevant audiences can access directly those persons or agencies that have things to disseminate.

5. *Finally, there are two little-used agencies that might well play more prominent and effective roles in dissemination than is now the case* These are the professional association and the university. Professional associations can access their own members readily and frequently have the means for dissemination, e.g., journals or trade magazines, already in hand. Their members tend to have confidence in them and to turn to the association for advice on many matters. And we speak here not only of advertisements or notices to be promulgated through association journals but also of other approaches such as displays at national conventions, articles specially prepared for their journals, special mailings to members, workshops and seminars in conjunction with national meetings, and other similar approaches.

Universities are also prime channels for dissemination. They train virtually all the professionals who become involved in facilitation programs, not only at the pre-professional level but also in-service. Instruction remains the primary mode of dissemination, and as the major agency for instruction the university is a pre-eminent disseminator. Universities have a history of interest in public service and in many sectors have established service agencies (e.g., Bureaus of Research and Service in schools of education). Thus, the resources which universities typically have invested in the service arena can be exploited for our purposes as well. Universities are seen as objective institutions with no axe to grind; when they engage in dissemination, their motives are not suspect in the same way as are those of agencies that evidently profit from their activities. For these reasons it seems appropriate to open communication with universities about ways and means for involving them effectively in dissemination.

Epilog

The two areas which the present Task Force was asked to consider—evaluation and dissemination—are rather different from one another. Moreover, the Task Force had to prepare its report in the absence of specific information about program recommendations, since these were being prepared elsewhere. Nevertheless, the above recommendations seem to the group to be useful and provocative at least at these two levels:

1) as *directives* to the evaluator and/or disseminator about activities that should be undertaken, and

2) as *criteria* useful in judging evaluations and disseminations after the fact to test whether they have been carried out in as meaningful a way as possible.

We urge their consideration in both these senses.

References

* Eisner, Elliot. *The Educational Imagination.* New York, NY: The MacMillan Co., 1979, *passim.*